

228012

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85

21748

1. FOR
STATE
REGISTRAR

CLARA M. O'CONNOR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Clara M. O'CONNOR			2a. DATE OF DEATH MONTH DAY YEAR 8/13/85		2b. HOUR 1101 PM	
3 SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 7/10/1899		6 AGE (IN YEARS LAST BIRTHDAY) 88 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore County, MD.	
10. CITY OR TOWN OF DEATH Randallstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore County General Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) AT Home		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY BALTIMORE	13c. CITY OR TOWN CAROLAN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2905 Summit Ave. 21234
14. FATHER'S NAME FIRST MIDDLE LAST George A. Cox		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret B. Payne				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217034366		17. INFORMANT ADDRESS FAMILY RECORDS		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause lost.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

10 days

weeks

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

Auto. Renal failure

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 8/12/85 to 8/13/85, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Walter Copeland MD		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22f. DATE SIGNED 8/13/85	
22c. PHYSICIAN'S NAME (TYPE OR PRINT) Walter Copeland MD		22e. ADDRESS 8726 Lytle Plaza Mall Randallstown MD 21133					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE Aug. 16, 1985	23c. NAME OF CEMETERY OR CREMATORY Moreland Mem. PK.	23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MARYLAND
24. FUNERAL DIRECTOR NAME ADDRESS EVANS CHAPLOF MEMORIES HARFORD RD. 8300		25a. DATE REC'D. BY REGISTRAR AUG 14 1985	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be immediately filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 and return them to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

232020

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

21749

1. DECEASED NAME (TYPE OR PRINT) Naomi D. O'Connor			2a. DATE OF DEATH MONTH DAY YEAR August 6, 1985			2b. HOUR P 12:15 AM		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 1 17 00		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Towson Balto. County MD.		
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Stella Maris Hospice				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk		12b. KIND OF BUSINESS OR INDUSTRY Laundry
13a. STATE Md.			13b. COUNTY Balto.		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST William Dean			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Fran Mathews			16. ADDRESS 13 Dublin Drive Lutherville, Md.		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			16b. SOCIAL SECURITY NO. 217-18-3065		17. INFORMANT Ms. Angela O'Connor			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), (c), (d), (e), (f), (g), (h), (i), (j), (k), (l), (m), (n), (o), (p), (q), (r), (s), (t), (u), (v), (w), (x), (y), (z), (aa), (ab), (ac), (ad), (ae), (af), (ag), (ah), (ai), (aj), (ak), (al), (am), (an), (ao), (ap), (aq), (ar), (as), (at), (au), (av), (aw), (ax), (ay), (az), (ba), (bb), (bc), (bd), (be), (bf), (bg), (bh), (bi), (bj), (bk), (bl), (bm), (bn), (bo), (bp), (bq), (br), (bs), (bt), (bu), (bv), (bw), (bx), (by), (bz), (ca), (cb), (cc), (cd), (ce), (cf), (cg), (ch), (ci), (cj), (ck), (cl), (cm), (cn), (co), (cp), (cq), (cr), (cs), (ct), (cu), (cv), (cw), (cx), (cy), (cz), (da), (db), (dc), (dd), (de), (df), (dg), (dh), (di), (dj), (dk), (dl), (dm), (dn), (do), (dp), (dq), (dr), (ds), (dt), (du), (dv), (dw), (dx), (dy), (dz), (ea), (eb), (ec), (ed), (ee), (ef), (eg), (eh), (ei), (ej), (ek), (el), (em), (en), (eo), (ep), (eq), (er), (es), (et), (eu), (ev), (ew), (ex), (ey), (ez), (fa), (fb), (fc), (fd), (fe), (ff), (fg), (fh), (fi), (fj), (fk), (fl), (fm), (fn), (fo), (fp), (fq), (fr), (fs), (ft), (fu), (fv), (fw), (fx), (fy), (fz), (ga), (gb), (gc), (gd), (ge), (gf), (gg), (gh), (gi), (gj), (gk), (gl), (gm), (gn), (go), (gp), (gq), (gr), (gs), (gt), (gu), (gv), (gw), (gx), (gy), (gz), (ha), (hb), (hc), (hd), (he), (hf), (hg), (hh), (hi), (hj), (hk), (hl), (hm), (hn), (ho), (hp), (hq), (hr), (hs), (ht), (hu), (hv), (hw), (hx), (hy), (hz), (ia), (ib), (ic), (id), (ie), (if), (ig), (ih), (ii), (ij), (ik), (il), (im), (in), (io), (ip), (iq), (ir), (is), (it), (iu), (iv), (iw), (ix), (iy), (iz), (ja), (jb), (jc), (jd), (je), (jf), (jg), (jh), (ji), (jj), (jk), (jl), (jm), (jn), (jo), (jp), (jq), (jr), (js), (jt), (ju), (jv), (jw), (jx), (jy), (jz), (ka), (kb), (kc), (kd), (ke), (kf), (kg), (kh), (ki), (kj), (kk), (kl), (km), (kn), (ko), (kp), (kq), (kr), (ks), (kt), (ku), (kv), (kw), (kx), (ky), (kz), (la), (lb), (lc), (ld), (le), (lf), (lg), (lh), (li), (lj), (lk), (ll), (lm), (ln), (lo), (lp), (lq), (lr), (ls), (lt), (lu), (lv), (lw), (lx), (ly), (lz), (ma), (mb), (mc), (md), (me), (mf), (mg), (mh), (mi), (mj), (mk), (ml), (mm), (mn), (mo), (mp), (mq), (mr), (ms), (mt), (mu), (mv), (mw), (mx), (my), (mz), (na), (nb), (nc), (nd), (ne), (nf), (ng), (nh), (ni), (nj), (nk), (nl), (nm), (nn), (no), (np), (nq), (nr), (ns), (nt), (nu), (nv), (nw), (nx), (ny), (nz), (oa), (ob), (oc), (od), (oe), (of), (og), (oh), (oi), (oj), (ok), (ol), (om), (on), (oo), (op), (oq), (or), (os), (ot), (ou), (ov), (ow), (ox), (oy), (oz), (pa), (pb), (pc), (pd), (pe), (pf), (pg), (ph), (pi), (pj), (pk), (pl), (pm), (pn), (po), (pp), (pq), (pr), (ps), (pt), (pu), (pv), (pw), (px), (py), (pz), (qa), (qb), (qc), (qd), (qe), (qf), (qg), (qh), (qi), (qj), (qk), (ql), (qm), (qn), (qo), (qp), (qq), (qr), (qs), (qt), (qu), (qv), (qw), (qx), (qy), (qz), (ra), (rb), (rc), (rd), (re), (rf), (rg), (rh), (ri), (rj), (rk), (rl), (rm), (rn), (ro), (rp), (rq), (rr), (rs), (rt), (ru), (rv), (rw), (rx), (ry), (rz), (sa), (sb), (sc), (sd), (se), (sf), (sg), (sh), (si), (sj), (sk), (sl), (sm), (sn), (so), (sp), (sq), (sr), (ss), (st), (su), (sv), (sw), (sx), (sy), (sz), (ta), (tb), (tc), (td), (te), (tf), (tg), (th), (ti), (tj), (tk), (tl), (tm), (tn), (to), (tp), (tq), (tr), (ts), (tt), (tu), (tv), (tw), (tx), (ty), (tz), (ua), (ub), (uc), (ud), (ue), (uf), (ug), (uh), (ui), (uj), (uk), (ul), (um), (un), (uo), (up), (uq), (ur), (us), (ut), (uu), (uv), (uw), (ux), (uy), (uz), (va), (vb), (vc), (vd), (ve), (vf), (vg), (vh), (vi), (vj), (vk), (vl), (vm), (vn), (vo), (vp), (vq), (vr), (vs), (vt), (vu), (vv), (vw), (vx), (vy), (vz), (wa), (wb), (wc), (wd), (we), (wf), (wg), (wh), (wi), (wj), (wk), (wl), (wm), (wn), (wo), (wp), (wq), (wr), (ws), (wt), (wu), (wv), (ww), (wx), (wy), (wz), (xa), (xb), (xc), (xd), (xe), (xf), (xg), (xh), (xi), (xj), (xk), (xl), (xm), (xn), (xo), (xp), (xq), (xr), (xs), (xt), (xu), (xv), (xw), (xx), (xy), (xz), (ya), (yb), (yc), (yd), (ye), (yf), (yg), (yh), (yi), (yj), (yk), (yl), (ym), (yn), (yo), (yp), (yq), (yr), (ys), (yt), (yu), (yv), (yw), (yx), (yy), (yz), (za), (zb), (zc), (zd), (ze), (zf), (zg), (zh), (zi), (zj), (zk), (zl), (zm), (zn), (zo), (zp), (zq), (zr), (zs), (zt), (zu), (zv), (zw), (zx), (zy), (zz)) Heart disease								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Long's head fracture fracture								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 2300 Dulaney Valley Rd. Towson, Md. 21204			
22a. I certify that (I) (this hospital) attended the deceased from June 26 , 19 84 , to August 6 , 19 85 , that (I) (we) last saw the deceased alive on July 15 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.								
22b. SIGNATURE Dr. Eddie Nakhuda			22c. DEGREE MD			22d. DATE SIGNED AUG 13 1985		
22e. PHYSICIAN'S NAME (TYPE OR PRINT)			22f. ADDRESS 2300 Dulaney Valley Rd. Towson, Md. 21204					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal			23b. DATE 8/6/85		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE Balto., Md.	
24. FUNERAL DIRECTOR NAME Anatomy Board			25a. DATE REC'D. BY REGISTRAR AUG 13 1985			25b. REGISTRAR'S SIGNATURE John Davidson		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and return page 2 to the funeral director. Page 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the Medical Examiner must be notified of a death.

335030

21:31 2002 12:12

TOWSON

Stellie Marie Hopkins

TOWSON

Handwritten signature: Stellie Marie Hopkins

July 12 1982

5100 Parkway Valley Rd. Towson, Md. 21204

233100

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

5

21750

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Theodore Casmir Olszewski			2a. DATE OF DEATH MONTH 8 DAY 15 YEAR 85		2b. HOUR 4:30 AM
3. SEX Male	4. RACE White	5. DATE OF BIRTH 12¹⁰ 18 1911		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS	IF UNDER 1 YEAR MONTHS 0 DAYS 0
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.		
10. CITY OR TOWN OF DEATH Essex	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 524 Wje Rd.		12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) retired	12b. KIND OF BUSINESS OR INDUSTRY GM	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE Md.	13b. COUNTY Balto.	13c. CITY OR TOWN Essex	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 524 Wje Rd. 21221	
14. FATHER'S NAME FIRST John MIDDLE Olszewski LAST			15. MOTHER'S MAIDEN NAME FIRST Elizabeth MIDDLE Purulewska LAST		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 216073247	17. INFORMANT ADDRESS Richard Berkenkemper 3Kerria Lane 21221		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple myeloma DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 yrs. 8 mos.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from June 1, 1984 to June 6, 1985 , that (I) (we) last saw the deceased alive on June 6, 1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE R. Humphrey	DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/15/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard L. Humphrey MD		22e. ADDRESS Johns Hopkins Oncology Center			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial	23b. DATE 8/17/85	23c. NAME OF CEMETERY OR CREMATORY Van Dine	23d. LOCATION CITY OR TOWN Balto COUNTY MD		
24. FUNERAL DIRECTOR NAME Connelly Funeral Home ADDRESS 300 Mac Ave. 21221			25a. DATE REC'D. BY REGISTRAR AUG 16 1985		

MEDICAL CERTIFICATION

001685



RECEIVED
MAY 11 1961
U.S. AIR FORCE

227055

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Katherine OSBORN			2a. DATE OF DEATH MONTH DAY YEAR August 12, 1985		2b. HOUR 11:50p M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 17, 1908		
6. AGE (IN YEARS LAST BIRTHDAY) 77		IF UNDER 1 YEAR MONTHS DAYS 77		IF UNDER 24 HRS. HOURS MIN. 77		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County		10. CITY OR TOWN OF DEATH Rosedale		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY		13a. STREET ADDRESS / ZIP CODE 6134 Fairdel Avenue 21206		
13a. STATE Md.		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		
14. FATHER'S NAME FIRST MIDDLE LAST James Santmyer		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Laura Poole		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no		
16b. SOCIAL SECURITY NO. 216-05-7184		17. INFORMANT ADDRESS D. Mr. Frank L. Osborn Jr. Same		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Pulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Sepsis with Left Cerebrovascular Accident DUE TO, OR AS A CONSEQUENCE OF (c)		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (H) (this hospital) attended the deceased from July 22 , 19 85 , to August 12 , 19 85 , that (H) (we) last saw the deceased alive on August 12 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (H) (we) (did) (did not) view the body after death.				
22b. SIGNATURE Geoffrey D. Sloan, M.D.		DEGREE M.D.		22c. DATE SIGNED 8/12/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Geoffrey D. Sloan, M.D.		22e. ADDRESS 9000 Franklin Sq. Dr., 21237				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug. 16, 1985		23c. NAME OF CEMETERY OR CREMATORY Woodlawn		
23d. LOCATION CITY OR TOWN COUNTY STATE Woodlawn Balto. Md.		24. FUNERAL DIRECTOR NAME ADDRESS Leonard H. Ruck Inc. Baltimore, Maryland				
25a. DATE REC'D. BY REGISTRAR AUG 13 1985		25b. REGISTRAR'S SIGNATURE Richard R. Rindell				

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP
DHMH - 16 50M 4/83
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or called.

© 1995

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2001, 51, 211-216.

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9 [unclear]

[Caption]

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[illegible]

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20010 00000 10000 4000

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TCVLD 002

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Leonor & John Inc., Portland, Oregon

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

21752

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Helen Lina Otto			2a. DATE OF DEATH MONTH DAY YEAR August 22, 1985		2b. HOUR 12:27P _M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 5 29 1891	6. AGE (IN YEARS LAST BIRTHDAY) 94	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Germany	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.		
10. CITY OR TOWN OF DEATH Rossville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY Homemaking	
13a. STATE Maryland	13b. COUNTY Baltimore Co.	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 1 Haylock Court 21236	
14. FATHER'S NAME FIRST MIDDLE LAST Karl Thalheim		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Freda Mader		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No	
16b. SOCIAL SECURITY NO. 214-74-5063		17. INFORMANT Kenneth J. Otto 4607 Hydes Rd. Hydes, Md. 21082			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease - Cardiac arrest.</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>disease - Cardiac arrest.</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Semile Dementia.</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) (this hospital) attended the deceased from <u>2/20/1982</u> to <u>8/22/1985</u> , that (we) last saw the deceased alive on <u>8/22/1985</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>[Signature]</u>		DEGREE M.D.		22c. DATE SIGNED 8/23/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Khim Tun		22e. ADDRESS 8400 Loch Raven Blvd. (Basement office)			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-26-85		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland		24. FUNERAL DIRECTOR NAME ADDRESS Sassah Fun Home 7401 Belair Rd. #			
25a. DATE RECD. BY REGISTRAR 10628166		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified without delay.

BP



246016

Item 21d 30/85 mtb F#607

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

21 / 53

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) WALTER CLINTON OWENS			2a. DATE KNOWN OF DEATH ESTIMATED 8-22-85			2b. HOUR 10:30		
3. SEX MALE	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR 9 25 1952	6. AGE (IN YEARS) (LAST BIRTHDAY) 33 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7c. DATE PRONOUNCED DEAD 8-23-85		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County		
10. CITY OR TOWN OF DEATH BALTIMORE COUNTY		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4200 blk. Spring Avenue				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CAB DRIVER		12b. KIND OF BUSINESS OR INDUSTRY ARROW
13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 6007 HIGHGATE DRIVE, 21215		
14. FATHER'S NAME FIRST MIDDLE LAST FREDERICK S. OWENS, SR.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST PALESTINE YOUNG					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-62-8077		17. INFORMANT ADDRESS PALESTINE E. SCOTT, 6007 HIGHGATE DRIVE				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot wounds of head</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? 8-7-85 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) subject found shot				
21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY STREET, FACTORY, FARM, ETC. Roadside		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 4200 blk. Spring Avenue Balto. Co., Md.				
22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>Margarita A. Korell</i>		TITLE (SPECIFY) Assistant			MEDICAL EXAMINER		DATE SIGNED 8-24-85	
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.		ADDRESS 111 Penn Street						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 8/29/1985		23c. NAME OF CEMETERY OR CREMATORY GARRISON FOREST		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE COUNTY		
24. FUNERAL DIRECTOR NAME ADDRESS WALTER & SONS FUNERAL HOME, INC. 2501 GWYNNS FALLS PARKWAY				25a. DATE REC'D. BY REGISTRAR AUG 29 1985		25b. REGISTRAR'S SIGNATURE <i>G. Davidson Handell</i>		

MEDICAL CERTIFICATION

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
25M

BP
DHMH - 17
(VR A15 ME (5))

340010



5-13-17 10:00 AM

WILLIAM D. WOOD

WILLIAM D. WOOD

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 1 7 5 4

REG. NO.

FOR
STATE
REGISTRAR

221140			1 - FOR STATE REGISTRAR			DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
Kathryn G. PARKER			August 6 1985			10 ⁰⁰ AM								
1. SEX Female			4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR Sept. 28 1902			6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.			IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Illinois			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.					
10. CITY OR TOWN OF DEATH Ruxton			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6601 Darnell Rd.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY Own Home					
13a. STATE Md.			13b. COUNTY Balto.			13c. CITY OR TOWN Ruxton			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 6601 Darnell Rd. 21204		
14. FATHER'S NAME FIRST MIDDLE LAST Daniel Wellington Guise			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edith Sinn											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-22-8000			17. INFORMANT David B. Baker Jr.			ADDRESS Same					
18. CAUSE OF DEATH (Enter only one cause per line from 18a and 18b) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Congestive Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cerebrovascular Disease</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>Years</u> <u>2 wks</u>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>None</u>														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from <u>8/1/85</u> to <u>8/6/85</u> , that (I) (we) last saw the deceased alive on <u>8/1/85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <u>William F. Fritz M.D.</u>						DEGREE <u>M.D.</u>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>8/6/85</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William F. Fritz M.D.						22e. ADDRESS 2 West University Pkwy. 21218								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 8-7-85			23c. NAME OF CEMETERY OR CREMATORY Green Mount			23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.					
24. FUNERAL DIRECTOR NAME ADDRESS Henry W. Jenkins & Sons Co., Balto., Md.						25a. DATE REC'D. BY REGISTRAR AUG 7 1985			25b. REGISTRAR'S SIGNATURE <u>Gina Davidson-Rendell</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Signatures should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 21755	
1- FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Viola Elizabeth Parker						2a. DATE OF DEATH MONTH DAY YEAR August 19, 1985		2b. HOUR M M			
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 1, 1902		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.					
10 CITY OR TOWN OF DEATH Middle River 21220		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3506 Buckboard Lane				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Middle River		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3506 Buckboard Lane 21220			
14. FATHER'S NAME FIRST MIDDLE LAST Joshua Boyd Noyes				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Charolette Howard							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -		17. INFORMANT Clara Claudy, Daughter		ADDRESS Same					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO RESPIRATORY FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) Cancer of Cervix DUE TO, OR AS A CONSEQUENCE OF (c) multiple Metastasis PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) ASTHMA & Anemia									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 10 - 1984 to 8 - 1985 , that (I) (we) last saw the deceased alive on 8-19-1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22c. DATE SIGNED	
22b. SIGNATURE BA YIN OUNG				DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BA YIN OUNG, M.D., P.A.				22e. ADDRESS 8022 BELAIR RD. BALTO., MD. 21236							
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 8/21/85		23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.					
24. FUNERAL HOME Bruzdzinski Funeral Home PA 1407 Old Eastern Ave				25a. DATE REC'D. BY REGISTRAR AUG 20 1985		25b. REGISTRAR'S SIGNATURE Jana Davidson-Hardell					

BP

1
RECEIVED
JAN 10 1962

WALSH

TO: DIRECTOR, FBI
FROM: SAC, NEW YORK
SUBJECT: [Illegible]
[Illegible text follows, appearing to be a memorandum or letter body with multiple paragraphs.]

226107

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

21750

1. DECEASED NAME (TYPE OR PRINT) HENRY DICKERSON PARKS			2a. DATE OF DEATH MONTH DAY YEAR AUGUST 9, 1985			2b. HOUR 10:00A _M				
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR AUGUST 10, 1898		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.				
10. CITY OR TOWN OF DEATH OVERLEA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 14 MADELINE AVENUE				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SECURITY		12b. KIND OF BUSINESS OR INDUSTRY MARTIN CO.		
13a. STATE MARYLAND			13b. COUNTY BALTIMORE		13c. CITY OR TOWN OVERLEA		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME (FIRST MIDDLE LAST) MELVIN PARKS			15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) IDA COLE							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II		17. INFORMANT ADDRESS 21206 MYRTLE PARKS 14 MADELINE AVE. BALTO. MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Heart Failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerotic cardiovascular disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Diabetes mellitus</i> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hr 1960 1964	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION (STREET CITY OR TOWN COUNTY STATE)					
22a. I certify that (I) (the hospital) attended the deceased from <i>June 24, 1985</i> to <i>July 8, 1985</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) follow the body after death.										
22b. SIGNATURE <i>Wynne H. Wong</i>			DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>Aug 9 1985</i>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Wynne H. Wong</i>			22e. ADDRESS <i>6801 Belair Rd 21206</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE AUG. 13, 1985		23c. NAME OF CEMETERY OR CREMATORY SLIPS CREEK CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE SUGAR GROVE SMITH VIRGINIA			
24. FUNERAL DIRECTOR NAME DIPPEL FUNERAL HOMES INC 7110 BELAIR RD. BALTIMORE MD. 21206			25a. DATE REC'D. BY REGISTRAR AUG 12 1985			25b. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>				

MEDICAL CERTIFICATION

83

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and to properly fill in item 24, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical history must be notified at once.

BP

701833



219061

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PW-1, RETURN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

21757

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH			MONTH DAY YEAR			2b. HOUR			
HOWARD			W.			PATCHETT, Sr.			8-1-85			19			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		2d. HOUR	
Male		White		2 10 31		54 YRS.		MONTHS DAYS		HOURS MIN.		8-1-85		19 6:30P	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland				U.S.A.								Baltimore County			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
Towson				Detention Center - Balto. Co. Jail				Plasterer				Kora & Williams Corp.			
13a. STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?			
Maryland				Baltimore				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS			
												2013 Wilhelm Street 21223			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME				16a. WAS DECEASED EVER IN U.S. ARMED FORCES?				16b. SOCIAL SECURITY NO.			
Robert				Martha G. Seymour				YES <input type="checkbox"/> NO <input type="checkbox"/>				220-26-8136			
17a. ADDRESS				17. INFORMANT				17b. ADDRESS				17c. ADDRESS			
N. Lucille Patchett				2013 Wilhelm St.				21223							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease															
DUE TO, OR AS A CONSEQUENCE OF															
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.															
(b) _____															
DUE TO, OR AS A CONSEQUENCE OF															
(c) _____															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?			
												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
				HOUR A.M. MONTH DAY YEAR											
				P.M. 19											
21d. INJURY OCCURRED				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION							
WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/>								STREET CITY OR TOWN COUNTY STATE							
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>															
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED				8-1-85			
Margarita A. Korell, M.D.				Assistant											
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS				111 Penn Street							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION			
Burial				8/5/85				Crownsville Vet. Cem.				Crownsville A.A. Maryland			
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE							
Hubbard Funeral Home, Inc.				4107 Wilkens Ave.				AUG 5 1985				The Davidson Handwritten			

07/B4
25M

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DHMH - 17
(VR A15 ME (5))



234123

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. XC 00538159

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) EDWARD GEORGE PAUL			2a. DATE OF DEATH MONTH DAY YEAR AUGUST 10, 1985		2b. HOUR 9:28 a.m.
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR JAN 21, 1897	6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.		
10. CITY OR TOWN OF DEATH FORT HOWARD	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VAMC FORT HOWARD, MARYLAND		12a. USUAL OCCUPATION (TYPE OF WORK AND LAST OF WORKING LIFE) Auto Mechanic	12b. KIND OF BUSINESS OR INDUSTRY self-employed	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND			13b. COUNTY BALTIMORE	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST CHARLES PAUL			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNIE E. THOMAS		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. WW I 213 09 4631		17. INFORMANT ADDRESS Helen E. Paul 8630 Sandplain Rd. 21222	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MINUTES	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u>				YEARS	
DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (this hospital) attended the deceased from <u>3/20/85</u> , 19 <u>85</u> , to <u>8/10</u> , 19 <u>85</u> , that (we) lost saw the deceased alive on <u>8/10</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>George J. Vellani</i>				22c. DATE SIGNED 8/10/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GEORGE J. VELLANIKARAN, M.D.				22e. ADDRESS VA MEDICAL CENTER, FT. HOWARD, MD. 21052	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 8-13-85	23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Balto. Md.
24. FUNERAL DIRECTOR NAME ADDRESS LASSAUN FUNERAL HOME BELAIR RD 1401		25a. DATE REC'D. BY REGISTRAR AUG 14 1985	25b. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>

BP
DHMH - 16 60M 7/B4
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and the death certificate has been filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. If the death certificate is to be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examination should be completed by a medical examiner.

MEDICAL CERTIFICATION

30113

13011 101100 1002



238043

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

5

21759

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST (Netta) MIDDLE LAST JESSIE F. PAULSEN		2a. DATE OF DEATH MONTH DAY YEAR 08 19 '85		2b. HOUR 7:30A M	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 4 7 08	
6. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Scotland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. AGE (IN YEARS LAST BIRTHDAY) 77 YRS	
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Scotland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		9. BALTIMORE CITY OR COUNTY OF DEATH baltimore COUNTY MD.	
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GREATER BALTIMORE MEDICAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	
13a. USUAL RESIDENCE (IF MARITAL HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Penna.		13b. COUNTY Alleghany		13c. CITY OR TOWN Pittsburgh	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4705 5th Avenue Apt 21 1521			
14. FATHER'S NAME FIRST MIDDLE LAST Daniel Dempster		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Christina McLaren			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 187-36-3403		17. INFORMANT ADDRESS Ms. Christine Barnes Baltimore 21217	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CARCINOMA OF ESOPHAGUS</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a					
19a. DATE OF OPERATION 5/10/85		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED CARCINOMA OF ESOPHAGUS		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>6/15</u> , 19 <u>85</u> , to <u>8/19</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>8/19</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Stanley A. Wilkins JNO		DEGREE MD		22c. DATE SIGNED 8-19-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) STANLEY A. WILKINS, M.D.		22e. ADDRESS GBMC - 6701 N. CHARLES STREET 21204			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 8-19-85		23c. NAME OF CEMETERY OR CREMATORY Security Process	
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.					
24. FUNERAL DIRECTOR NAME Cremation Society of Maryland Inc,		ADDRESS Balto. Md.		25a. DATE REC'D. BY REGISTRAR AUG 22 1985	
		25b. REGISTRAR'S SIGNATURE Edie Davidson-Rodette			

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226102

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

21760

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Minika T. Pedersen			2a. DATE OF DEATH MONTH DAY YEAR 8-10-85		2b. HOUR 7:35 A.M.		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 9 20 08		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS HOURS MIN. 76	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) DENMARK		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore Co. MD.	
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. Joseph Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NURSE		12b. KIND OF BUSINESS OR INDUSTRY STATE HOSP.	
13a. STATE md				13b. COUNTY BALTIMORE		13c. CITY OR TOWN 21204	
14. FATHER'S NAME FIRST MIDDLE LAST NIELSEN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) -----		17. INFORMANT ADDRESS CHRISTIAN J. PEDERSEN TOWSON, MD 21204			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Pneumonia and Renal failure

DUE TO, OR AS A CONSEQUENCE OF

(b)

Advanced carcinoma of stomach.

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Dr. Perry				DEGREE ATTENDING PHYSICIAN		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Perry				22e. ADDRESS			

23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE AUG. 12, '85		23c. NAME OF CEMETERY OR CREMATORY DULANEY VALLEY MEM. GAR.		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE CO., MD	
24. FUNERAL DIRECTOR NAME ADDRESS WILLIAM E. JOHNSON 8521 LOCH RAVEN BLVD.				25a. DATE REC'D. BY REGISTRAR AUG 12 1985			
				25b. REGISTRAR'S SIGNATURE Felix Davidson-Randall			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers, page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

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246006

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) DOROTHY M. PERKINS			2a. DATE OF DEATH MONTH DAY YEAR 8/27/85			2b. HOUR 5:25 M	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR March 6 1920	6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.				
10. CITY OR TOWN OF DEATH Towson	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Manor Care Towson		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Md.		13b. COUNTY BALTO.	13c. CITY OR TOWN BALTO.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 3219 Berkshire Rd. 21214		
14. FATHER'S NAME FIRST MIDDLE LAST William Hayden Ogden			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mae Victoria Hoffman				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no		16b. SOCIAL SECURITY NO. 218-03-3244		17. INFORMANT ADDRESS Edwin H. Perkins Jr. 3219 Berkshire Rd. 21214			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Ischemia		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year
DUE TO, OR AS A CONSEQUENCE OF (b) _____		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
Esophageal Cancer

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 3300 York Rd 85		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Baltimore Md.	
22a. I certify that (I) (this hospital) attended the deceased from 23 August 85 , 19_____, to _____, 19_____, that (I) (we)-last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Walter T. Kees		DEGREE MD		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Walter T. Kees		22e. ADDRESS Monkton Md 21115			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 8/31/85	23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.
24. FUNERAL DIRECTOR NAME Mitchell-Wiedefeld		ADDRESS 6500 York Rd.	
25a. DATE REC'D BY REGISTRAR AUG 29 1985		25b. REGISTRAR'S SIGNATURE John Davidson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove copies of pages 1 and 2 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85

21762

FOR
1 - STATE
REGISTRAR

REG. NO.

238035

1. DECEASED NAME (TYPE OR PRINT) VERA BOYD PFEIFFER			2a. DATE OF DEATH MONTH DAY YEAR August 20, 1985			2b. HOUR 3:15 P.M.				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 26, 1897		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.				
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Joseph's Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher - Retired Education		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland					13b. COUNTY Baltimore		13c. CITY OR TOWN Phoenix		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST William B. Boyd					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Georgia Miller					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-38-7153		17. INFORMANT ADDRESS Elmer C. Pfeiffer - Same as #13e						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chute heart attack</u> DUE TO, OR AS A CONSEQUENCE OF <u>ASCD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>domus</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE 1969 8-20-85					
22a. I certify that (I) (this hospital) attended the deceased from _____ to _____, that (I) (we) last saw the deceased alive on <u>Aug 15, 85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.										
22b. SIGNATURE <u>William C. Helfrich</u>			DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 8/21/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. William C. Helfrich			22e. ADDRESS 5006 Roland Ave., Balto., Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 8-21-85		23c. NAME OF CEMETERY OR CREMATORY Westview		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.			
24. FUNERAL DIRECTOR NAME Towson Funeral Home, Inc.			ADDRESS 1050 York Rd. Towson, Md. 21204		25a. DATE REC'D. BY REGISTRAR AUG 22 1985		25b. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u>			

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

21763

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Joseph			2a. DATE OF DEATH KNOWN ESTIMATED <input checked="" type="checkbox"/> 6 15 85			2b. HOUR 0100			
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 11 21 22	6. AGE (IN YEARS) LAST BIRTHDAY 62 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 8 15 85	2d. HOUR 1200			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County			
10. CITY OR TOWN OF DEATH Dundalk		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (NOTIFY SUCH FACILITY GIVE STREET ADDRESS) 11 Roseview Rd.			12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Machinist		12b. KIND OF BUSINESS OR INDUSTRY Martins		
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 13b. COUNTY Baltimore 13c. CITY OR TOWN Dundalk			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 11 Roseview Rd. 21222				
14. FATHER'S NAME FIRST MIDDLE LAST Jack Piccolomini			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jennie						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) Yes		(IF YES, DATE WAR OR DATES) WWII		16b. SOCIAL SECURITY NO. 090128632		17. INFORMANT ADDRESS Helen Piccolomini 11 Roseview Rd.			
18. CAUSE OF DEATH (Enter only one cause permitted for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic ischemic myocardial disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .									
ACTUAL SIGNATURE J. Crossan O'Donovan			M.D. Deputy			MEDICAL EXAMINER		DATE SIGNED 8/15/85	
EXAMINER'S NAME (TYPE OR PRINT) J. CROSSAN O'DONOVAN			ADDRESS 2112 Dundalk Ave., Balto., Md. 21222						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Buried		23b. DATE 6/17/85		23c. NAME OF CEMETERY OR CREMATORY Holly Hill		23d. LOCATION Stade River Balto. Md.			
24. FUNERAL DIRECTOR Connolly Funeral Home				ADDRESS 500 Mace Ave. 21221		25a. DATE REC'D. BY REGISTRAR AUG 16 1985		25b. REGISTRAR'S SIGNATURE John Davidson	

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FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FRANCES MAY POTTERFIELD			2a. DATE OF DEATH MONTH DAY YEAR August 1, 1985		2b. HOUR 9:45 a
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Feb. 1 1907		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6401 Loch Raven Blvd.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY Own Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE Maryland	13b. COUNTY Balto.	13c. CITY OR TOWN Balto.	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 6401 Loch Raven Blvd. 21239	
14. FATHER'S NAME FIRST MIDDLE LAST Charles P. Kirby		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Leona Haight			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-09-9942		17. INFORMANT ADDRESS Frank E. Potterfield Jr. Lutherville, Md.	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertension</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>AS CVD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>immed</u> <u>6 yrs</u> <u>6 yrs.</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (1) this hospital attended the deceased from <u>6/1/79</u> to <u>8/1/85</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above.					
22b. SIGNATURE <u>George T. Gilmore</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/8/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. George T. Gilmore M.D.		22e. ADDRESS 1717 York Rd. Lutherville, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 8-5-85	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.	
24. FUNERAL DIRECTOR NAME ADDRESS Henry W. Jenkins & Sons Co., Balto., Md.		25a. DATE REC'D. BY REGISTRAR AUG 6 1985		25b. REGISTRAR'S SIGNATURE <u>W. W. Jenkins</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

21763

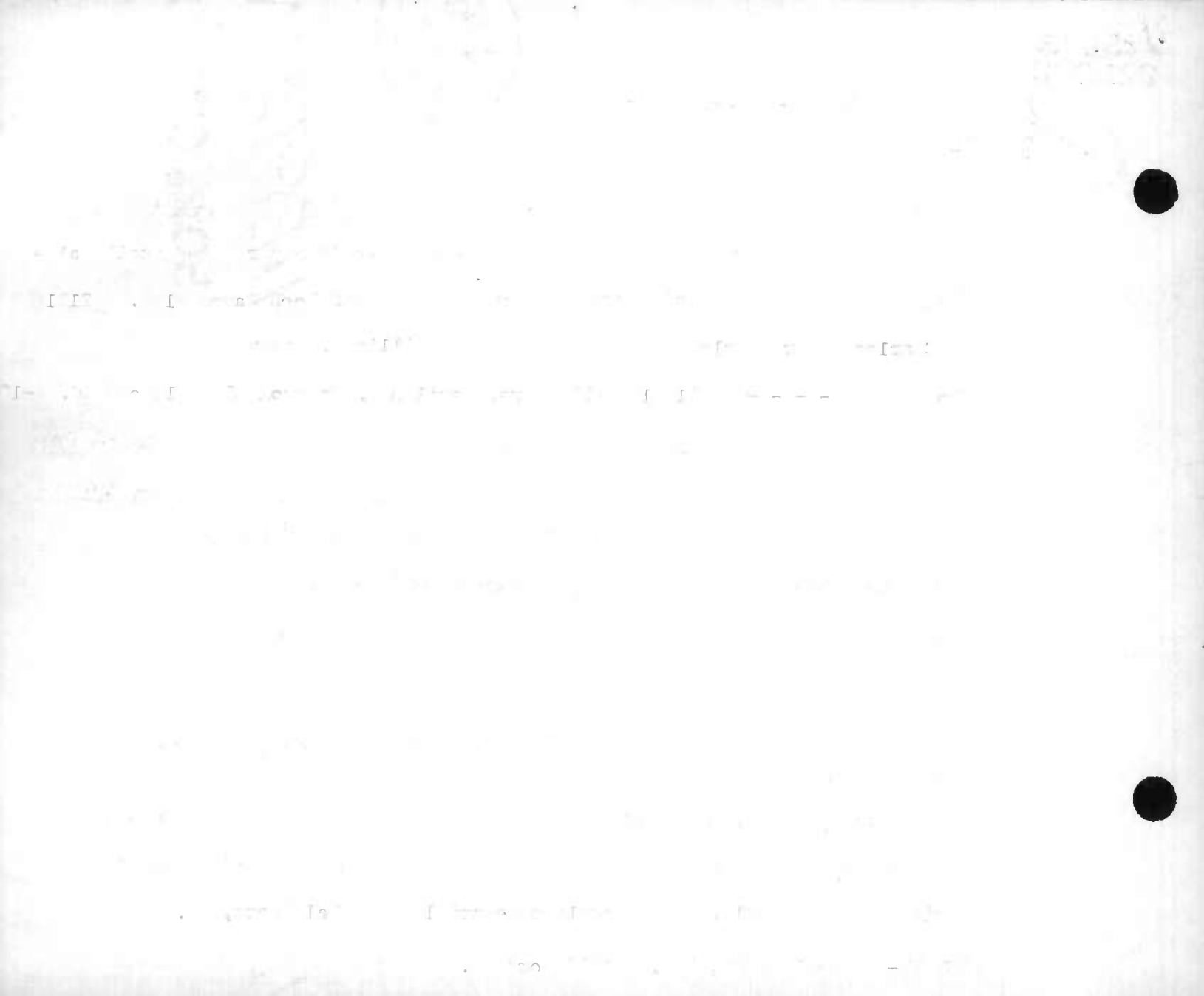
1. DECEASED NAME (TYPE OR PRINT) MADELEINE H. POTTS			2a. DATE OF DEATH MONTH 8 DAY 8 YEAR 85			2b. HOUR 1237 AM				
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH 8 DAY 8 YEAR 03		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALT. COUNTY MD.				
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VALLEY NURSING CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ass't Buyer		12b. KIND OF BUSINESS OR INDUSTRY Retail Sales		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 4230 Loch Raven Blvd. 21218	
14. FATHER'S NAME FIRST Charles Edward MIDDLE Hurley LAST				15. MOTHER'S MAIDEN NAME FIRST Lillie M. MIDDLE Haney LAST						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 215 10 6622		17. INFORMANT ADDRESS Mrs. Marilyn H. Cameron 3 Englewood Rd. -10						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEPSIS SEPTICEMIA								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH seven DAYS		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF (c) CHRONIC OBSTRUCTIVE PULMONARY DISEASE								14 DAYS		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (c) SENILE ONSET, DEMENTIA; PARKINSON'S DISEASE										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (1) (this hospital) attended the deceased from September 1984 to July 1985 , that (1) (we) lost saw the deceased alive on JULY 1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.										
22b. SIGNATURE GARY A. MANKO				DEGREE MD				22c. DATE SIGNED 8-8-1985		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GARY A. MANKO, M.D.				22e. ADDRESS 11 E. CHESTNUT HILL LN, REGISTERSTOWN, MD						
23a. BURIAL, CREMATION, REMOVAL (CHECK ONE) Burial		23b. DATE 8/10/85		23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Pk			23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.			
24. FUNERAL DIRECTOR NAME MITCHELL-WIEDEFELD HOME, INC. ADDRESS 6500 York Rd.				25a. DATE REC'D. BY REGISTRAR AUG 9 1985		25b. REGISTRAR'S SIGNATURE J. Davidson-Rendall				

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health officer with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



225035

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILLIAM DORSEY PRITCHARD, JR.			2a. DATE OF DEATH MONTH DAY YEAR AUGUST 7, 1985			2b. HOUR M				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 5, 1904		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.				
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 704 Sussex Rd.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Treasurer		12b. KIND OF BUSINESS OR INDUSTRY American Bank Stationary		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Towson		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 704 Sussex Rd. 21204	
14. FATHER'S NAME FIRST MIDDLE LAST William Dorsey Pritchard					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mae McCarthy					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 212-03-1438		17. INFORMANT ADDRESS Mary Ellen Garrity 4611 Keswick Rd. Baltimore, Md. 21210					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Ischemic Cardiac Disease DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 years										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Chronic obstructive airway disease										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 6/29/70 19 70 to 8/8/85 19 85 , that (I) (we) lost saw the deceased alive on Aug 7 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Samuel I. O'Mansky			DEGREE M.D.			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED Aug 9/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Samuel I. O'Mansky, M.D.			22e. ADDRESS 8405 Loch Raven Blvd. Baltimore, Md. 21204							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE Aug. 12, 1985		23c. NAME OF CEMETERY OR CREMATORY Greenmount		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City, Maryland			
24. FUNERAL DIRECTOR NAME Mitchell-Wiedefeld Home, Inc.			ADDRESS 6500 York Rd. Balto., Md. 21212		25a. DATE REC'D. BY REGISTRAR AUG 9, 1985		25b. REGISTRAR'S SIGNATURE [Signature]			

BP _____

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NOT
MAILED

RECEIVED

240111

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

21767

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Giovanni (James) Battista Promutico			2a. DATE OF DEATH MONTH DAY YEAR 8 20 1985		2b. HOUR 1:30 P.M.				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 7 31 1925		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH Catonsville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 21228 2115 Alvin Ave. Catonsville, Md.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		12b. KIND OF BUSINESS OR INDUSTRY Maintenance		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Catonsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Vincenzo Promutico			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rosa Varallo						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Korea		17. INFORMANT ADDRESS Genevieve Promutico Same as 13e.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO-PULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ACUTE UNKNOWN PRIMARY EMBOLI</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ILLEGAL CROST</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 MIN 2 MONTHS		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on <u>8/19/85</u> 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (we) (did not) view the body after death.									
22b. SIGNATURE Mary T. Behrens			DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 8-21-85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Mary T. Behrens			22e. ADDRESS Baltimore, Md. Lock Raven VA. Med. Center						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8/23/85		23c. NAME OF CEMETERY OR CREMATORY Garrison Forest Veterans Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Owings Mills Maryland		
24. FUNERAL DIRECTOR NAME Leroy M. & Russell C. Witzke Funeral Home					25a. DATE REC'D. BY REGISTRAR AUG 23 1985		25b. REGISTRAR'S SIGNATURE John Davidson-Randall		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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226070

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

21769

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JAMES L. RALEIGH			2a. DATE OF DEATH MONTH DAY YEAR Aug 7 '85		2b. HOUR MIN. 7:23 P.M.	
3. SEX M		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 6 16 20		
6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS.		7. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S.C.		9. BALTIMORE CITY OR COUNTY OF DEATH COUNTY (BALTIMORE) MD.				
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. JOSEPH HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
12b. KIND OF BUSINESS OR INDUSTRY						
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 716 Richwood Ave. 21212				
14. FATHER'S NAME FIRST MIDDLE LAST Lawrence Raleigh		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ada Gladden				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. 248-14-7144		17. INFORMANT ADDRESS Rose Raleigh 716 Richwood Ave.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Myocardial Infarction, acute DUE TO, OR AS A CONSEQUENCE OF (b) Hypertensive - Arteriosclerotic Cardiovascular Dis. DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Obstructive Lung Disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 18 hrs. 9 yrs.						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a Gastrointestinal Hemorrhage - source ?						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 8-5-85		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 8-7-85		
22a. I certify that (I) (the hospital) attended the deceased from 8-5-85 to 8-7-85 that (I) (we) last saw the deceased alive on 8-7-85 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Wm Carl Ebeling		DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8-7-85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wm CARL EBELING, M.D.		22e. ADDRESS 7401 Oak St., Balto., Md. 21204				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/12/85		23c. NAME OF CEMETERY OR CREMATORY md. Nat'l mem. Ph		
23d. LOCATION CITY OR TOWN COUNTY STATE Laurel MD						
24. FUNERAL DIRECTOR NAME Wm. C. March & H		ADDRESS 1101 E. North Ave		25a. DATE REC'D. BY REGISTRAR AUG 9, 1985		
25b. REGISTRAR'S SIGNATURE Wm. C. March & H						

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85

21770

219073

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
ROBERT P. REILLY			AUGUST 5, 1985			7:20AM		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
MALE	WHITE	MARCH 1, 1936	49			MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH					
PENNSYLVANIA	U.S.A.		BALTIMORE COUNTY, MD.					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
21234	2123 WILKER AVENUE		OWNER			RESTAURANT		
13a. STATE			13b. COUNTY			13c. CITY OR TOWN		
MARYLAND			BALTIMORE			21234		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME					
PETER P. REILLY			FLORENCE M. GINTHER					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT		
NO			215-30-4812			CAROLE S. REILLY 2123 WILKER AVE. 21234		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:		
IMMEDIATE CAUSE (a) <u>Metastatic Carcinomatosis</u>		<u>6 months</u>
DUE TO, OR AS A CONSEQUENCE OF		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	(b) <u>Cancer of Tongue</u>	<u>1 1/2 yrs</u>
DUE TO, OR AS A CONSEQUENCE OF		
(c)		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>10 - 19 84</u> to <u>8 - 5 - 19 85</u> , that (I) (we) last saw the deceased alive on <u>8 - 4 - 19 85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.			
22b. SIGNATURE <u>Francis T. Daly</u>		DEGREE <u>M.D.</u>	22c. DATE SIGNED <u>8-5-85</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) FRANCIS T. DALY, M.D.		22e. ADDRESS 7401 OSLER DRIVE 825-2442	

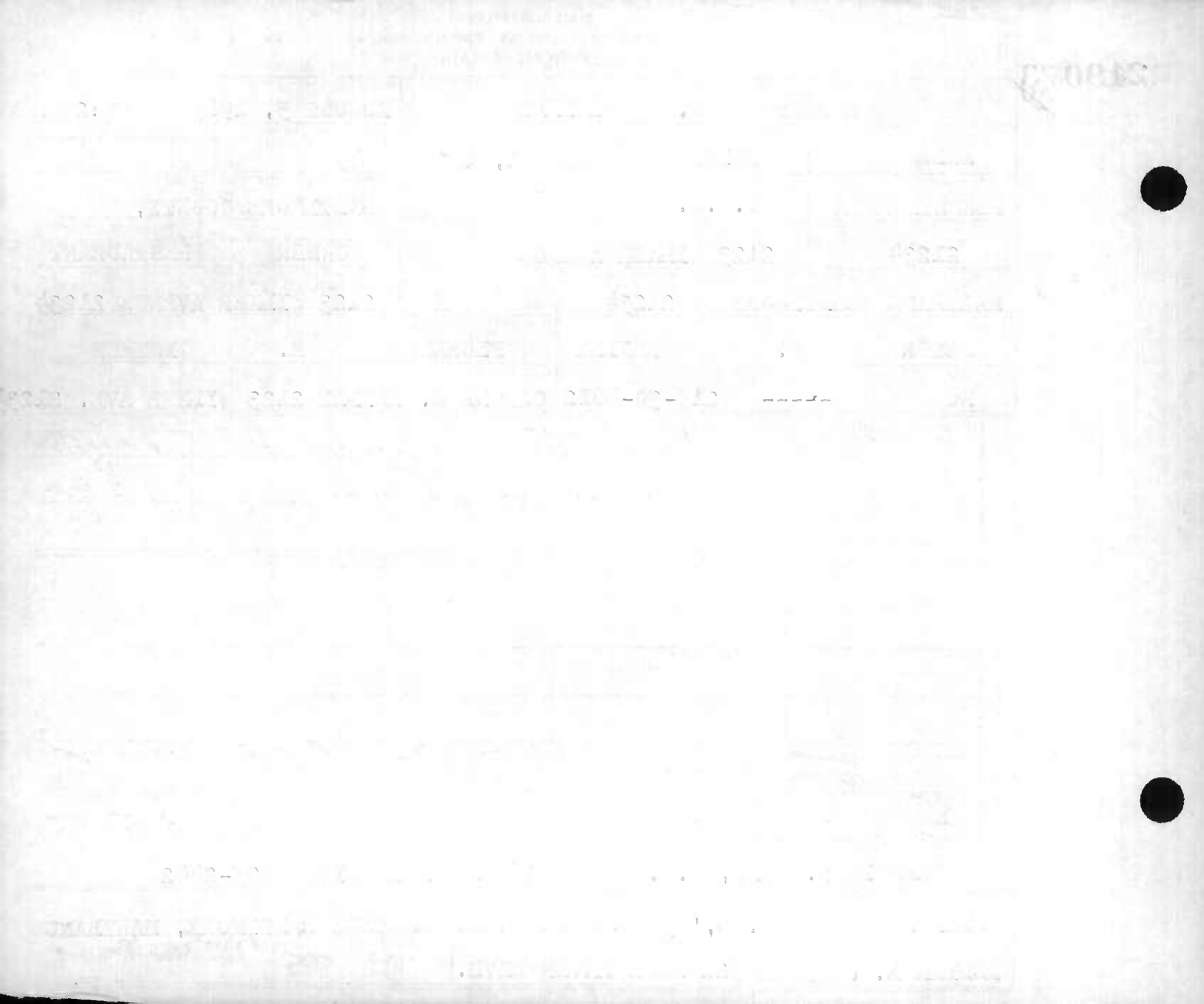
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
BURIAL	AUG. 8, '85	HOLY REDEEMER CEMETERY	BALTIMORE, MARYLAND
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR	
WILLIAM E. JOHNSON		AUG 5 1985	
ADDRESS		REGISTRAR'S SIGNATURE	
8521 LOCH RAVEN BLVD.		<u>William E. Johnson</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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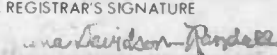


225011

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Louis Remmers		2a. DATE OF DEATH MONTH DAY YEAR August 5, 1985		2b. HOUR 2:25a_M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 7 8 02	
6. AGE (IN YEARS LAST BIRTHDAY) 83		7. BIRTHPLACE (STATE OR FOREIGN) Maryland		8. CITIZEN OF WHAT COUNTRY? USA	
9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County		10. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Guard Matheison Co.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital	
12. CITY OR TOWN OF DEATH Rosedale		13. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		14. STREET ADDRESS / ZIP CODE 134 Linden Road 21061	
15. FATHER'S NAME FIRST MIDDLE LAST Lewis August Remmers		16. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Elizabeth Rae		17. INFORMANT ADDRESS Mr. George Gilbert Same as #13	
18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		18b. SOCIAL SECURITY NO. 213-10-8425		18c. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic obstructive pulmonary disease DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (c) Congestive heart failure	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NO! WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that he (this hospital) attended the deceased from July 23, 19 85 to August 5, 19 85 that he (we) last saw the deceased alive on August 5, 19 85 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above to (we) (did) (did not) view the body after death.					
22b. SIGNATURE 		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED August 5, 1985	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Johnson		22e. ADDRESS 9000 Franklin Square Drive, 21237			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-8-85		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery Brooklyn A.A. Md.	
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md. 21225		24. FUNERAL DIRECTOR NAME Patapsco Ave. 257		25a. DATE REC'D. BY REGISTRAR AUG 8 1985	
25b. REGISTRAR'S SIGNATURE 					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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212029

FOR Film G607 item 13e
1- STATE REGISTRAR 9/3/85 rja

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

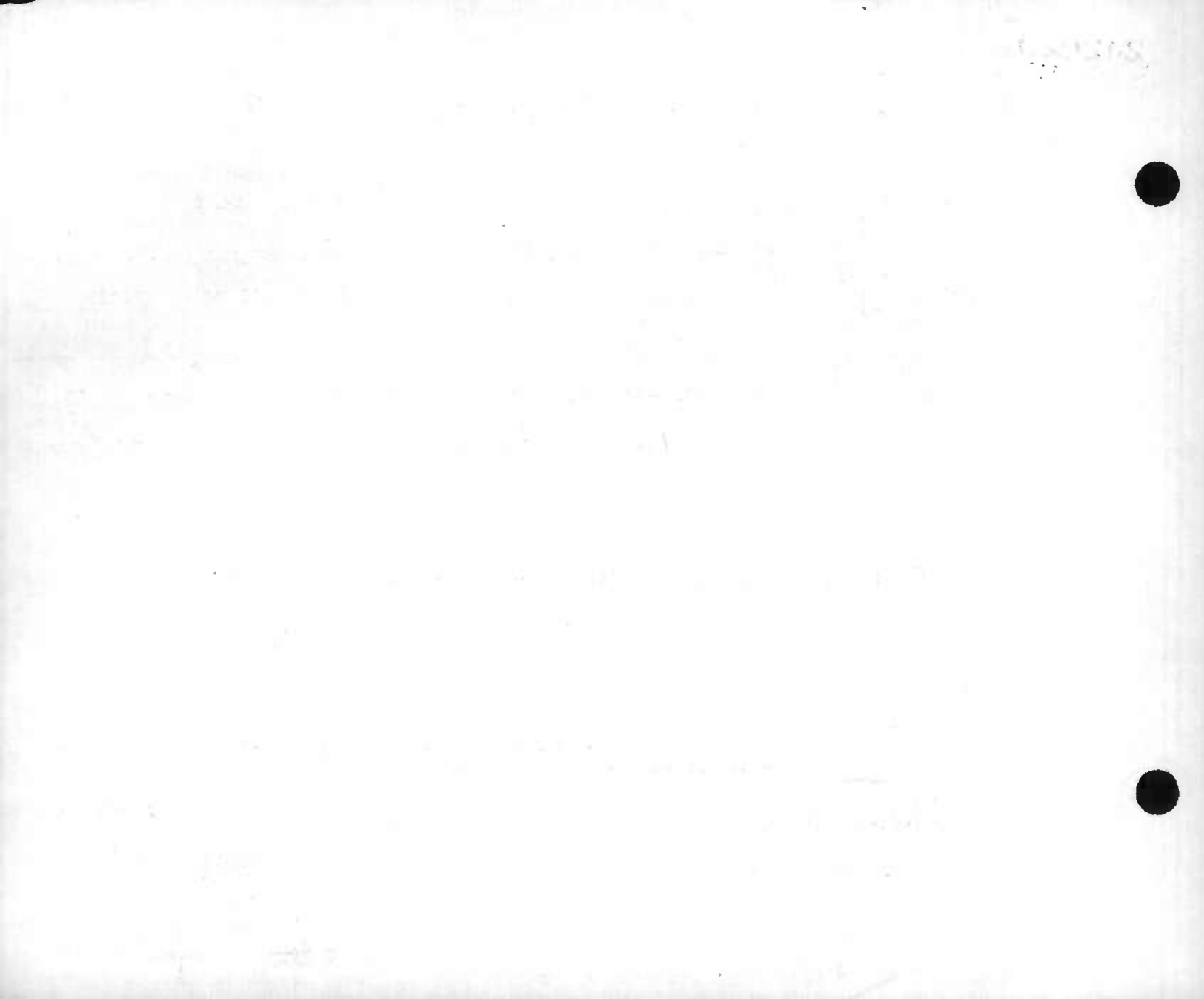
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Wheatley R. Reynolds</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>8-27-85</i>		2b. HOUR MIN. <i>12 25 AM</i>					
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>July 17, 1903</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <i>82</i>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore County</i> MD.				
10. CITY OR TOWN OF DEATH <i>Parkville</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Perring Parkway Nursing Home</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Retired Manager</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Y.M.C.A.</i>		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Maryland</i>			13b. COUNTY <i>Baltimore</i>		13c. CITY OR TOWN <i>Baltimore</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>3808 Kimble Rd 21218</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Francis Reynolds</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Emma Rush</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>No</i>			16b. SOCIAL SECURITY NO. <i>220-30-0584</i>		17. INFORMANT ADDRESS <i>Mrs Bertha Reynolds Same As 13e</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Renal failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>48 hours</i>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Parkinson's disease with organic brain syndrome</i>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>August 26, 1985</i> to <i>Aug 27, 1985</i> , that (I) (we) last saw the deceased alive on <i>August 26, 1985</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.										
22b. SIGNATURE <i>R. Donald Jandorf</i>			DEGREE <i>M.D.</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>8-27-85</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>R. Donald Jandorf M.D.</i>			22e. ADDRESS <i>7403 Harford Rd Baltimore, Maryland</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>8/29/85</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Moreland Mem Park</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore Maryland</i>			
24. FUNERAL DIRECTOR NAME <i>Leonard J Ruck Inc. Baltimore, Maryland</i>			ADDRESS			25a. DATE REC'D. BY REGISTRAR <i>AUG 28 1985</i>				

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed within 12 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



227118

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

5 21 / 73

1. DECEASED NAME (TYPE OR PRINT) COLETTA Mary RHODES		2a. DATE OF DEATH MONTH DAY YEAR 8-6-85		2b. HOUR 1:40 PM	
3. SEX FEMALE		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 6-22-12	
6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) USA MD		8. CITIZEN OF WHAT COUNTRY? USA	
9. BALTIMORE CITY OR COUNTY OF DEATH BALTO., County MD		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. JOSEPH Hosp	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Home maker		12b. KIND OF BUSINESS OR INDUSTRY Home		13. STREET ADDRESS / ZIP CODE 916 Bernadette Dr. 21050	
14. FATHER'S NAME FIRST MIDDLE LAST Patrick J. Kilbane		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Burke		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no	
17. SOCIAL SECURITY NO. 277-12-6498A		18. INFORMANT Mr. Donald Rhodes Jr.		19. ADDRESS 916 Bernadette Dr. Forest Hill, Md, 21050	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) COPD DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Chronic	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: ASCVD, Severity					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (I) (did) not view the body after death.					
22b. SIGNATURE J. DAVID NARR, MD				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS	
J. DAVID NARR, MD				1205 YORK RD CATHERINE A1	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-10-1985		23c. NAME OF CEMETERY OR CREMATORY St. Ignatius C. Ch. Cem.	
24. FUNERAL DIRECTOR NAME ADDRESS E.F. Lassahn, 11750 Belair Rd. Kingsville, Md. 21087		25. DATE RECD. BY REGISTRAR AUG 12 1985		26. REGISTRAR'S SIGNATURE J. Davidson-Rhodes	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 993 as a clear death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner will be notified.

REVISED



20% COTTON FIBER

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2nd WORK IN COTTON (2nd)

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1st WORK IN COTTON (1st)

246024

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST SEVASTI D. RICAS			2a. DATE OF DEATH MONTH DAY YEAR August 22, 1985		2b. HOUR M M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR October 26, 1912		6. AGE (IN YEARS LAST BIRTHDAY) YRS 72	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Greece	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Pikesville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Pikesville Conv. Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY Own Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE Maryland	13b. COUNTY Baltimore	13c. CITY OR TOWN Timonium	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 5 L Quiet Stream Ct. 21093	
14. FATHER'S NAME FIRST MIDDLE LAST James Doukas			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-54-0428		17. INFORMANT ADDRESS Timothy A. Ricas-1402 Shefford Rd. 21239	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Colon Carcinoma with DUE TO, OR AS A CONSEQUENCE OF (b) diffuse metastases liver, Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) lung. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 8/18 19 85 to 8/22 19 85 , that (I) (we) last saw the deceased on 8/22 19 85 and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Dr. Harold B. Bob		DEGREE MD		22c. DATE SIGNED 8/25/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Harold B. Bob		22e. ADDRESS 7220 Park Heights Ave. 21215			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 8-26-85	23c. NAME OF CEMETERY OR CREMATORY Greek Orthodox		23d. LOCATION CITY OR TOWN COUNTY STATE Woodlawn Balto. Md.	
24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc. Towson, Md. 21204		ADDRESS 1050 York Rd.		25a. DATE REC'D. BY REGISTRAR AUG 27 1985	25b. REGISTRAR'S SIGNATURE [Signature]

MEDICAL CERTIFICATION

TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 3 and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified (p. 4).

548054



240065

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) LEONARD M. RICE, SR.			7a. DATE OF DEATH MONTH DAY YEAR AUGUST 24, 1985		7b. HOUR 12:10P
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR NOV. 14 1919	6. AGE (IN YEARS LAST BIRTHDAY) 65	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY		
10. CITY OR TOWN OF DEATH CATONSVILLE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 311 MONTROSE AVENUE		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RESEARCH PROFFES.		12b. KIND OF BUSINESS OR INDUSTRY SELF -EMPLOYED
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE MARYLAND	13b. COUNTY BALTIMORE	13c. CITY OR TOWN CATONSVILLE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 311 MONTROSE AVENUE 21228	
14. FATHER'S NAME FIRST MIDDLE LAST MARCUS RICE		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FRANCIS JAFFE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II	17. INFORMANT ADDRESS Leonard Rice, Jr. 311 Montrose Avenue 21228		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma of Lung		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) _____		
DUE TO, OR AS A CONSEQUENCE OF (c) _____		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 7/1 , 19 75 , to 8/24 , 19 85 , that (I) (we) lost saw the deceased alive on 8/23 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE DR. KROOPNICK	DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 8/24/85
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. KROOPNICK		22e. ADDRESS NORTH ARUNDAL HOSPITAL	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION	23b. DATE 8/26/85	23c. NAME OF CEMETERY OR CREMATORY Security Process	23d. LOCATION CITY OR TOWN COUNTY STATE Catonville Baltimore Maryland
24. FUNERAL DIRECTOR NAME ADDRESS HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVENUE 21229		25a. DATE REC'D. BY REGISTRAR AUG 26 1985	
		25b. REGISTRAR'S SIGNATURE John Davidson-Rodriguez	

240002



240082

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ANDREW ANTHONY RICHKUS			2a. DATE OF DEATH MONTH DAY YEAR AUGUST 22, 1985		2b. HOUR M
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR JULY 10, 1910		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.	
10. CITY OR TOWN OF DEATH LANSDOWNE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 417 CALEDONIA AVENUE		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) TAILOR	12b. KIND OF BUSINESS OR INDUSTRY CLOTHING	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND					
13b. COUNTY BALTIMORE		13c. CITY OR TOWN LANSDOWNE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE 417 CALEDONIA AVE 21227					
14. FATHER'S NAME FIRST MIDDLE LAST ALEXANDRIA RICHKUS			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARTHA WALLACE		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR NAVAL) 1929-1936		17. INFORMANT ADDRESS MRS. EVELYN M. RICHKUS 417 CALEDONIA	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>metastatic colon cancer</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we (did) did not view the body after death.					
22b. SIGNATURE <u>Dr. N. Butt</u>		DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/23/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. N. BUTT, M.D.		22e. ADDRESS 6325 WASHINGTON BLVD ELKRIDGE SHOPPING CENTER 21227			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 8/26/85	23c. NAME OF CEMETERY OR CREMATORY MARYLAND VETERANS		23d. LOCATION CITY OR TOWN COUNTY STATE CROWNSVILLE A.A. MARYLAND	
24. FUNERAL DIRECTOR NAME AMBROSE, INC. 1328 SULPHUR SPRING ROAD		25a. DATE REC'D. BY REGISTRAR AUG 26 1985		25b. REGISTRAR'S SIGNATURE <u>Davidson</u>	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 2 and 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



234166

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72-hour after-death report with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked on item 18, show any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

21777

1. DECEASED NAME (TYPE OR PRINT) LEAH K RIMBACH			2a. DATE OF DEATH MONTH DAY YEAR AUGUST 16 1985			2b. HOUR MIN. 11:30 P.M.			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 6 12 69		6. AGE (IN YEARS LAST BIRTHDAY) 16 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 16	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTO. Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE Co. Md. MD.			
10. CITY OR TOWN OF DEATH DWINGS MILLS		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ROSEWOOD CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NONE		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.			13b. CITY OR TOWN CARROLL WOODBINE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 21797 7575 OLD WASHINGTON RD.		
14. FATHER'S NAME (FIRST MIDDLE LAST) LOUIS G. RIMBACH			15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) BARBARA BOARDMAN						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO			16b. SOCIAL SECURITY NO. NONE		17. INFORMANT ADDRESS MRS. BARBARA B. RIMBACH WOODBINE, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIO RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF (c) PROFOUND MENTAL RETARDATION, SPASTICITY, MOTOR DYSTONIA								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from SEPTEMBER 8, 1984 to AUGUST 16, 1985 , that (I) (we) last saw the deceased alive on AUGUST 10, 1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Jose Lito C. Ocampo						DEGREE M.D.		22c. DATE SIGNED 8/16/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOSE LITO C. OCAMPO, M.D.						22e. ADDRESS ROSEWOOD CENTER DWINGS MILLS MARYLAND 21117			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION			23b. DATE AUG. 17, 85		23c. NAME OF CEMETERY OR CREMATORY CARROLL CREMATION		23d. LOCATION CITY OR TOWN COUNTY STATE HAMPSSTEAD, Md.		
24. FUNERAL DIRECTOR NAME ELINE FUNERAL HOME						ADDRESS REISTERSTOWN, Md.		25a. DATE REC'D. BY REGISTRAR AUG 20 1985	
						25b. REGISTRAR'S SIGNATURE Jane Davidson-Randall			

BP

ELINE FUNERAL HOME REISTERSTOWN, MD.

CREMATION AUG. 17, 82 CARROLL CREMATION HANSPLEAD, MD.

NO

NONE

MRS. BARBARA B. RIMBACH WOODBINE, MD.

LOUIS

G.

RIMBACH

BARBARA

BOARDMAN

7525 OLD WASHINGTON RD.

NONE

BALTIMORE CO. MD.

USA

BALTO. MD.

246082

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
FIRST MIDDLE LAST CLIFTON ROBINSON			MONTH DAY YEAR 08/25/85			HOUR MIN. 3:40P		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
MALE	WHITE	MONTH DAY YEAR 8 3 1899	86 YRS			MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
BISHOP8s HEAD MD.	U.S.A.			BALTIMORE COUNTY MD.				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
TOWSON	GREATER BALTIMORE MEDICAL CTR.		RETIRED STEEL WORKER					

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE	
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	<input type="checkbox"/> NO <input type="checkbox"/>	111 BROOKBURY DR. APT. B2	
MD.	BALTIMORE	REISTERSTOWN			

14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME		
FIRST MIDDLE LAST FRED ROBINSON			FIRST MIDDLE LAST SUSANNE FLORENCE TRUITT		

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)	17. INFORMANT ADDRESS
No	213-07-1355	EUGENE C. ROBINSON 166 MAYBIN CIR.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:		
IMMEDIATE CAUSE (a) LUNG CANCER		
DUE TO, OR AS A CONSEQUENCE OF		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		
(b) _____		
DUE TO, OR AS A CONSEQUENCE OF		
(c) _____		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a-

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
				YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 8/23 19 85 to 8/25/ 19 85 , that (I) (we) lost 8/25/ 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (do) (did not) view the body after death.					
22b. SIGNATURE Robert A. VanBesien M.D.		DEGREE MD		22c. DATE SIGNED 8/25/85	
22d. PHYSICIAN'S NAME (PRINT)		22e. ADDRESS G.B.M.C. 6701 N. Charles Street			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
BURIAL	8/28/85	LORRAINE PARK CEM.	WOODLAWN MD.
24. FUNERAL DIRECTOR ELONE FUNERAL HOME 11824 REISTERSTOWN RD.		25a. DATE REC'D. BY REGISTRAR AUG 29 1985	
ADDRESS		25b. REGISTRAR'S SIGNATURE <i>Jane Davidson-Hendall</i>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

516085

MALE

WHITE

8

3 1899

86

BISHOPS HEAD MD. U.S.A. x

MD.

BALTIMORE REISTERSTOWN

111 BROOKBURY DR. APT. 82

FRED

ROBINSON

SUSANNE

FLORENCE TRUITT

NO

513-07-132 EUGENE C. ROBINSON 166 MAYBIN CIR.

BURIAL

8/28/82

LORRAINE PARK CEM. WOODLAWN

MD.

ELINE FUNERAL HOME 11824 REISTERSTOWN RD.

242111

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85

21779

FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Michele E. Roeheny			2b. DATE OF DEATH MONTH DAY YEAR 8 25 85			2c. HOUR 1 45 A M		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 5 15 52		6. AGE (IN YEARS LAST BIRTHDAY) 33 YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balto. county MD.		
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Stella Maris Hospice				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RN		
12b. KIND OF BUSINESS OR INDUSTRY Walter Reed								
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)								
13b. STATE MD		13c. COUNTY Balto.		13d. CITY OR TOWN Balto.		13e. STREET ADDRESS / ZIP CODE 20 Elinor Avenue - 21236		
14. FATHER'S NAME FIRST MIDDLE LAST Michael Roeheny				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Truchan				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-56-4924		17. INFORMANT ADDRESS Mr. Michael Roeheny - 20 Elinor Ave. - 21236				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Liver and Peritoneal Cancer DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) diabetes mellitus DUE TO, OR AS A CONSEQUENCE OF (c) 1st Kidney Transplant and x 1 yr ago PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)								
MEDICAL CERTIFICATION								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 8/19, 19 85, to 8/28, 19 85, that (I) (we) last saw the deceased alive on 8/24, 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE K.R. Faulkner MD				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/25/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kendall R. Faulkner, M.D.				22e. ADDRESS Stella Maris Hospice 2300 Dulaney Valley Rd. - Towson, MD 21204				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-28-85		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.		
24. FUNERAL DIRECTOR NAME John C. Miller Inc. - 6415 Belair Rd. - 21206 ADDRESS				25a. DATE REC'D. BY REGISTRAR AUG 26 1985		25b. REGISTRAR'S SIGNATURE June Davidson		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it is to be filed by the funeral director. Pages 3 and 4 should be detached for use at the funeral home permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

11515

233112

Items 18-22a 9/30/85 mth F#607

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

21 / 80
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE KNOWN OF DEATH			XX MONTH DAY YEAR			2b. HOUR																	
Michael			R.			Rockwell						8-14			19 85			4:32 a.																	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD			MONTH DAY YEAR			2d. HOUR																	
Male		White		April 9, 1962		23 YRS.						8-14			19 85			a.																	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH																							
Maryland				USA								Baltimore County, MD																							
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY																			
Rossville				Franklin Square Hospital								Laborer				Carpet Co.																			
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS																									
Maryland				Baltimore		Essex		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		27 Rumelia Circle 21221																									
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME						16a. WAS DECEASED EVER IN U.S. ARMED FORCES?						16b. SOCIAL SECURITY NO.						17. INFORMANT						ADDRESS					
Wade Rockwell						Dora Rockwell						No						218 82 5500						Dora B. Boyce, Mother						Same					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																	
PART I DEATH WAS CAUSED BY:																																			
IMMEDIATE CAUSE (a) Narcotism																																			
DUE TO, OR AS A CONSEQUENCE OF																																			
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.																																			
(b) DUE TO, OR AS A CONSEQUENCE OF																																			
(c)																																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																																			
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?												20. AUTOPSY?																	
																		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR						21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)																							
						P.M. 19																													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>						21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)						21f. LOCATION																							
												STREET CITY OR TOWN COUNTY STATE																							
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural cause <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																																			
ACTUAL SIGNATURE <i>Dennis F. Smyth</i> TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER DATE SIGNED 8-14-85																																			
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D. ADDRESS 111 Penn St., Balto., Md. 21201																																			
23a. BURIAL, CREMATION, REMOVAL						23b. DATE						23c. NAME OF CEMETERY OR CREMATORY						23d. LOCATION																	
Burial						8/17/85						Holly Hill Memorial Gardens						Baltimore Co., Md.																	
24. FUNERAL DIRECTOR <i>Przydzinski Funeral Home</i> ADDRESS 1407 Old Eastern Ave																		25a. DATE REC'D. BY REGISTRAR AUG 16 1985						25b. REGISTRAR'S SIGNATURE <i>William F. Fordell</i>											

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE BACK PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW-100. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGE 4 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07-B4
25M

BP 1278

DHMH - 17
(VR A15 ME (5))

511009

100-20202

7



100-20202

100-20202

246012

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) EDMUND L. ROE			2a. DATE OF DEATH MONTH DAY YEAR 8-24-85		2b. HOUR 2:45A M
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR June 19, 1903	6. AGE (IN YEARS LAST BIRTHDAY) 82		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.		
10. CITY OR TOWN OF DEATH CATONSVILLE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUMMIT NURSING HOME		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ENGINEER	12b. KIND OF BUSINESS OR INDUSTRY OIL CO.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE MARYLAND	13b. COUNTY BALTIMORE	13c. CITY OR TOWN CATONSVILLE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 1904 Cedar Circle 21228	
14. FATHER'S NAME FIRST MIDDLE LAST EDMUND L. ROE		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST GERTRUDE LITCHFIELD			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 225-10-9634	17. INFORMANT ADDRESS Maryland 21074 EDMUND L. ROE - 3404 Schaefer Dr. Hampstead			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHIMMEDIATE CAUSE (a) Acute bronchitis and congestive heart failure

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b) Chronic emphysema

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

Diabetes Mellitus Alzheimer's Disease

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>4-21</u> , 19 <u>84</u> , to <u>8-24</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>8-24</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <u>James E. Rowe</u>		22c. DATE SIGNED <u>8/26/85</u>	22d. ADDRESS 413 Commonwealth Ave., Catonsville, MD. 21228
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. James E. Rowe		22f. ADDRESS 413 Commonwealth Ave., Catonsville, MD. 21228	

MEDICAL CERTIFICATION

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Aug. 26, 1985	23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Woodlawn Baltimore MD.
24. PREPARED BY Leroy M. & Russell C. Witzke Funeral Home P.A. 1630 Edmondson Ave., Catonsville, MD. 21228		25a. DATE REC'D. BY REGISTRAR Aug 27 1985	25b. REGISTRAR'S SIGNATURE <u>John Davidson-Hendall</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, file it by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

THE HONORABLE

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219092

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

5 2 1 / 8 2

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Helen Dorothy Roe			2a. DATE OF DEATH MONTH DAY YEAR August 5, 1985			2b. HOUR 3:30 A.			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 28, 1909		6. AGE (IN YEARS LAST BIRTHDAY) 75		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, Md.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County, Md.			
10. CITY OR TOWN OF DEATH Catonsville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6314 Mt. Ridge Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Banking Clerk & Housewife---		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 13b. COUNTY Baltimore 13c. CITY OR TOWN Catonsville					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 6314 Mt. Ridge Road-21228		
14. FATHER'S NAME FIRST MIDDLE LAST Charles ----- Rusteberg					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Charlotte C. Baker				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ---		17. INFORMANT Ellicott City, Md. 21043 -Re. Eleanor K. Dasch-3354 N. Chatham Rd.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Breast Carcinoma DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from July 1982 to Aug 5 1985 , that (I) (we) last saw the deceased alive on June 19 85 , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Doris M. Hahn				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 8/5/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Doris M. Hahn				22e. ADDRESS 5601 Loch Raven Blvd 21239					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/7/85		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland			
24. FUNERAL DIRECTOR NAME Sterling Funeral Estate, P. A. ADDRESS 736 Edmondson Ave., Catonsville, Md. 21228				25a. DATE REC'D. BY REGISTRAR AUG 5 1985		25b. REGISTRAR'S SIGNATURE [Signature]			

MEDICAL CERTIFICATION

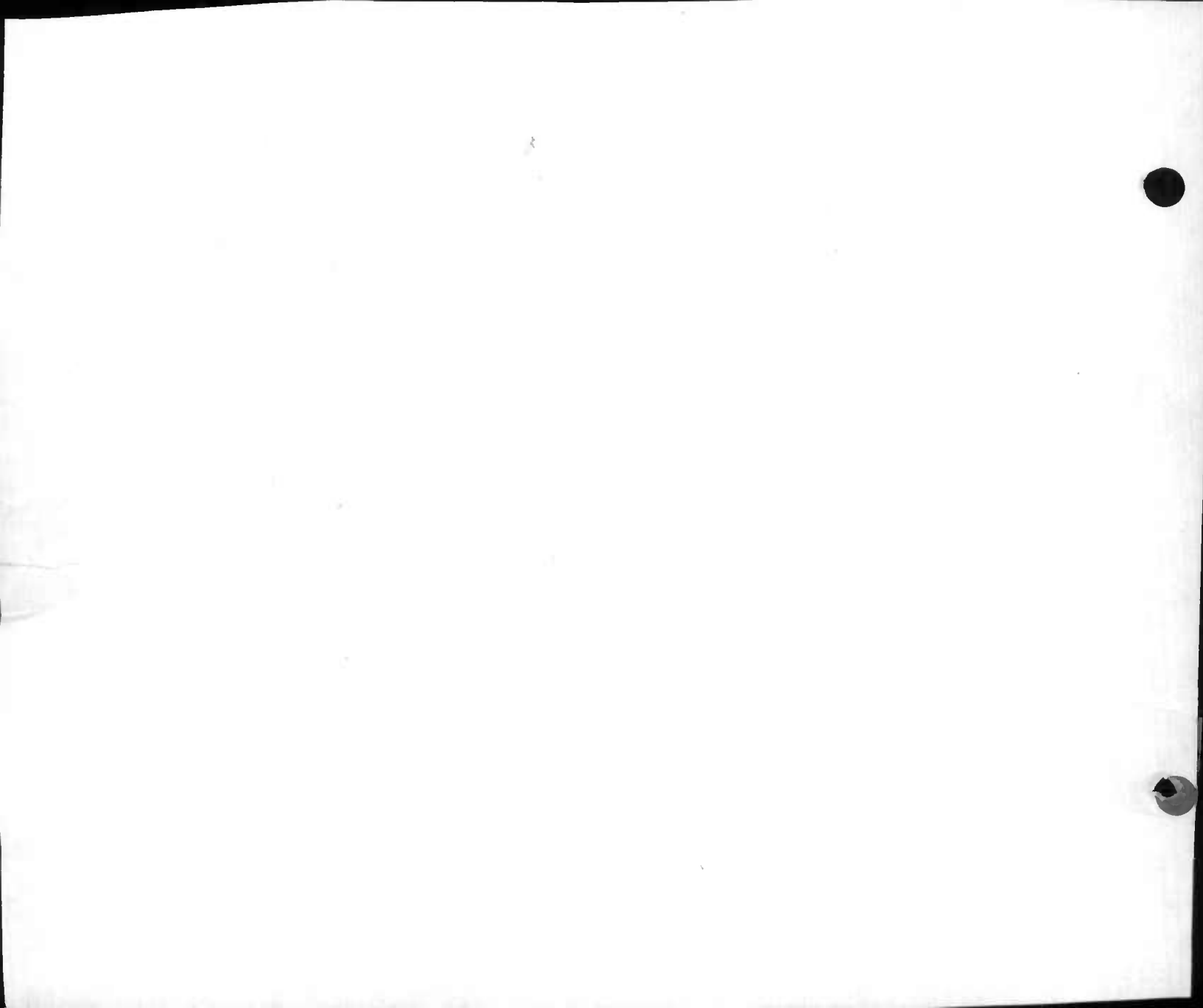
BP _____

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in accordance with the instructions on page 3, it should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. (IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.)

VOIDED DEATH CERTIFICATE NUMBER 85-21783



BP

DHMH - 16 60M 7/84
(VRA 15, 4)STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) MARIE A. ROMOSER			2a DATE OF DEATH MONTH DAY YEAR 8 13 '85			2b HOUR 5:20A M			
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR December 2, 1901		6 AGE (IN YEARS LAST BIRTHDAY) 83 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.			
10 CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN BALTIMORE CITY, GIVE STREET ADDRESS) GBMC-6701 N. CHARLES ST.				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b KIND OF BUSINESS OR INDUSTRY Own Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a STATE Maryland		13b COUNTY Baltimore		13c CITY OR TOWN Lutherville		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 11 Alston Rd. 21093	
14 FATHER'S NAME FIRST MIDDLE LAST Adam Miller				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gusta Virgus					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. 214-38-5534		17 INFORMANT ADDRESS Glen Arm, Md. Donald F. Romoser-6 Maybrook Ct. 21057					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>cerebral vascular accident</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>coronary artery disease, atrial fibrillation</u>									
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>8/8</u> 19 <u>85</u> to <u>8/13</u> 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>8/13</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.)									
22b. SIGNATURE <u>David Porter</u> M.D.				22c. DATE SIGNED <u>8/13/85</u>				22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>David Porter</u>	
22e. ADDRESS <u>c/o GBMC 6701 N Charles St Balto. MD</u>									
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 8-15-85		23c NAME OF CEMETERY OR CREMATORY Oaklawn		23d LOCATION CITY OR TOWN COUNTY STATE Balto. Md.			
24 FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc. Towson, Md. 21204				24b ADDRESS 1050 York Rd.		25a DATE REC'D. BY REGISTRAR AUG 19 1985		25b REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u>	

5 234042

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial/transfer permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18b has any injury, or other traumatic event, the medical examiner must be notified.

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WYRIE COUNTY

GRAND JURY

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

5 21785

1- FOR
STATE
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EDITH ROSENTHAL			2a DATE OF DEATH MONTH DAY YEAR AUG. 9, 1985			2b HOUR P 8:20 M			
3 SEX FEMALE		4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR DEC. 28, 1898		6 AGE (IN YEARS LAST BIRTHDAY) 86 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.			
10 CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DULANEY-TOWSON NURSING HOME				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SECRETARY		12b KIND OF BUSINESS OR INDUSTRY B&O RAILROAD	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY MARYLAND			13b CITY OR TOWN BALTIMORE		13c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d STREET ADDRESS / ZIP CODE APT. 115 6317 PARK HTS. AVE. #21215		
14 FATHER'S NAME FIRST MIDDLE LAST ISRAEL BENJAMIN			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST KATIE EDLOVITCH						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO.		17 INFORMANT MRS. RHONA DRUCK		APT. 10 3 POMONA NORTH BALTO., MD 21208			
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic organic brain syndrome</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE <u>Barry S. Gold M.D.</u>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 8/10/85	
22d PHYSICIAN'S NAME (TYPE OR PRINT) BARRY S. GOLD, M.D.						22e ADDRESS 6804 PARK HEIGHTS AVE. #21215			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b DATE AUG. 13, 1985		23c NAME OF CEMETERY OR CREMATORY HEBREW FRIENDSHIP		23d LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND		
24 FUNERAL DIRECTOR NAME ADDRESS SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD., BALTO., MD 21215						25a DATE REC'D. BY REGISTRAR AUG 20 1985		25b REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MEDICAL CERTIFICATION

BP _____

DHMH - 16 60M 7/84

(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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2089 COTTON FIBER



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Film G606 item 5

FOR 8/27/85 rja
1- STATE REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

5 2 1 7 8 6

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Benjamin O. Rowlands			2a. DATE OF DEATH MONTH DAY YEAR August 19, 1985			2b. HOUR 5:30 A.M.					
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 22, 1920		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.					
10. CITY OR TOWN OF DEATH Essex		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1826 Kitty Hawk Rd.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired-Dept. of Nat. Resources		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md.			13b. COUNTY Balto.		13c. CITY OR TOWN Essex		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1826 Kitty Hawk Rd. 21221		
14. FATHER'S NAME FIRST MIDDLE LAST Benjamin Rowlands				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mae Swartz				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII 203016894	
17. INFORMANT ADDRESS Dorothy Rowlands 1826 Kitty Hawk Rd. 21											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>EMACIATION, DEHYDRATION</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CECINOMA OF THE LARGE BOWEL</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>RECURRENT</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on <u>Aug 12</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Stephen C. Thaxton</u> 22c. DATE SIGNED						DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) STEPHEN C. THAXTON M.D.						22e. ADDRESS 6700 RIDGE ROAD, BALTIMORE, MD 21237					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8/22/85		23c. NAME OF CEMETERY OR CREMATORY Sacred Heart of Jesus			23d. LOCATION CITY OR TOWN COUNTY STATE Dundalk Balto. Md.			
24. FUNERAL DIRECTOR NAME Connelly Funeral Home						25a. DATE REC'D. BY REGISTRAR AUG 21 1985			25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		
ADDRESS 300 Mace Ave. 21221											

MEDICAL CERTIFICATION

BP
DHMH - 16 60M 7/84
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified and entry made on the death certificate.



248111

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85

21787

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Clarence T. RUBY, Sr.			2a. DATE OF DEATH MONTH DAY YEAR August 31, 1985		2b. HOUR 9:20 PM				
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 3-24-1909		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH BALTO.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANKLIN SQUARE HOSP.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MINER		12b. KIND OF BUSINESS OR INDUSTRY MINING.	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD.			13b. COUNTY BALTO.		13c. CITY OR TOWN BALTO.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 117 CONESTOGA RD. 21220	
14. FATHER'S NAME FIRST MIDDLE LAST JACOB RUBY			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST REBECCA FUSSELMAN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 196-09-18801			17. INFORMANT ADDRESS Mrs. Anna E. Ruby - 117 Conestoga Rd. 21220				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiopulmonary Failure

DUE TO, OR AS A CONSEQUENCE OF

(b) Left Cerebrovascular Accident (Stroke)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (c)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 8-27-85 to 8-31-85, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on 8-31-85, and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.							
22b. SIGNATURE 		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 8/31/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Gary Johnson, MD		22e. ADDRESS 9000 Franklin Square Dr. 21237					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 9-3-85		23c. NAME OF CEMETERY OR CREMATORY CRESTLAWN CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO., MD.	
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24. FUNERAL DIRECTOR 		25a. DATE REC'D. BY REGISTRAR SEP 3 1985		25b. REGISTRAR'S SIGNATURE 	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 1 7 8 8

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Marie Johanna Ruby			2a. DATE OF DEATH MONTH DAY YEAR August 8, 1985			2b. HOUR 9:20A M				
3 SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 15, 1893		6 AGE (IN YEARS LAST BIRTHDAY) 92 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.				
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1180 Newfield Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home		
13a. STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1180 Newfield Road 21207	
14. FATHER'S NAME FIRST MIDDLE LAST John Doyle			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary O'Keefe							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-02-7641		17. INFORMANT Joan D. Armstrong		ADDRESS Same as # 13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Possible Acute Coronary with</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cardiac Arrhythmia</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
27b. SIGNATURE <u>Helen de M. Brown</u>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		27c. DATE SIGNED 8/9/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Sabundayo M.D.				27e. ADDRESS 5550 Baltimore National Pike, Baltimore, Md.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/12/85		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.				
24. FUNERAL DIRECTOR Leroy M. & Russell C. Witzke Funeral Homes P.A. 1630 Edmondson Avenue, Catonsville, Md. 21228						25a. DATE REC'D. BY REGISTRAR AUG 9, 1985		25b. REGISTRAR'S SIGNATURE <u>Kelia Davidson-Randall</u>		

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
THEODORE RZEMIEN MEDICAL EXAMINER'S CERTIFICATE OF DEATH

21 / 89
REG. NO.

1- FOR STATE REGISTRAR		THEODORE RZEMIEN		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		21 / 89		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Theodore RZEMIEN				2a. DATE KNOWN OF DEATH ESTIMATED 8 10 1985		2b. HOUR 10:00		2c. DATE PRONOUNCED DEAD 8 11 1985	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Sept. 21, 1914 70 YRS.	6. AGE (IN YEARS) FACT BIRTHDAY 70 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS. HOURS MIN.	7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Rhode Island		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Rhode Island		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County			
10. CITY OR TOWN OF DEATH Catonsville		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 108 Melvin Avenue		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Warehouseman- General Electric		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland				13b. COUNTY Baltimore		13c. CITY OR TOWN Catonsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST John Rzemien				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Susan Kozime		16. ADDRESS 3 Amvet Drive 02762			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WW 2 038-10-0462		17. INFORMANT Theodore J. Rzemien					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASCVD DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .									
ACTUAL SIGNATURE Stanley Z. Elzberg		EXAMINER'S NAME (TYPE OR PRINT) STANLEY Z. Elzberg MD.		TITLE (SPECIFY) M.D. Deputy		MEDICAL EXAMINER		DATE SIGNED 8/11/85	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 8/12/85		23c. NAME OF CEMETERY OR CREMATORY Westview Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville Md.			
24. FUNERAL DIRECTOR Leroy M. & Russell C. Witake Funeral Homes P.A.				25a. DATE REC'D. BY REGISTRAR AUG 13 1985		25b. REGISTRAR'S SIGNATURE Jane Davidson-Randall			
1630 Edmondson Avenue, Catonsville, Md. 21229									

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the medical examiner be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the other papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

I. DECEASED NAME (TYPE OR PRINT) Sabina			LAST Saginar			2a. DATE OF DEATH MONTH DAY YEAR 7 24 85				2b. HOUR 8 16 PM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR DEC 12 04		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS				IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Romania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALT. County MD					
10. CITY OR TOWN OF DEATH Pikesville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Pikesville Nursing 7 Sudbrook				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary				12b. KIND OF BUSINESS OR INDUSTRY ?	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
13a. STATE MD		13b. COUNTY BALT		13c. CITY OR TOWN BALT		13e. STREET ADDRESS / ZIP CODE 2500 Belvedere Ave 21215					
14. FATHER'S NAME FIRST MIDDLE LAST Shmuel Tovi Lazarus				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah Lazarus							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 046-09-5476		17. INFORMANT ADDRESS J. Kennedy 126 Hawthorne Ave 21208							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiogenic shock DUE TO, OR AS A CONSEQUENCE OF (b) acute MI DUE TO, OR AS A CONSEQUENCE OF (c) ASCD										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) A/2 theme											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 1982 , 19 85 , to 7/24 , 19 85 , that (I) (we) lost above, (I) (we) (did) (did not) view the body after death, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated											
22b. SIGNATURE Louis W Miller DEGREE MD						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7/25/85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Louis W Miller						22e. ADDRESS 6604 Port Heights					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 7-28-85		23c. NAME OF CEMETERY OR CREMATORY BETH MOSES PYTHIAN CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE PINELAWN L.I. NY				
24. FUNERAL DIRECTOR NAME Hebrew Memorial F.H. ADDRESS BALT. MD 21208						25a. DATE REC'D. BY REGISTRAR SEP - 9 1985		25b. REGISTRAR'S SIGNATURE Gina Davidson			

BP

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252045

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

5 21791

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST TILLIE SALKIN			2a. DATE OF DEATH MONTH DAY YEAR AUGUST 31 1985		2b. HOUR 1:05 A.		
3 SEX FEMALE		4 RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR OCT. 23, 1886		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 98 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) AUSTRIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.	
10. CITY OR TOWN OF DEATH PIKESVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PIKESVILLE NURSING HOME		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY AT HOME	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST JACOB MOLITZ		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EREIDA UNKNOWN		16. STREET ADDRESS / ZIP CODE 2500 W. BELVEDERE AVE. APT. 413 #21215			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-32-5256		17. INFORMANT ADDRESS MRS. HANNAH FRIED APT. 520 6317 PARK HTS. AVE. BALTO., MD 21215			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anoxic aneurysm</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebrovascular accident</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypertension</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on <u>August 19, 85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Kenneth J. Glick</u>		DEGREE <u>M.D.</u>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>8-31-85</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KENNETH GLICK, M.D.				22e. ADDRESS 10219 S. DOLFIELD RD. OWINGS MILLS, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE SEPT. 1, 1985		23c. NAME OF CEMETERY OR CREMATORY PETACH TIKVAH		23d. LOCATION CITY OR TOWN COUNTY STATE ROSEDALE BALTO. MD	
24. FUNERAL DIRECTOR SOL LEVINSON & BROS., INC. NAME ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215				25a. DATE REC'D. BY REGISTRAR SEP 5 1985		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Russell</u>	

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20% COTTON FIBER

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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 5 2 1 7 9 2

1. DECEASED NAME (TYPE OR PRINT) Ernest L. Schaefer			2a. DATE OF DEATH MONTH DAY YEAR August 6 1985			2b. HOUR 7:19 PM			
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR November 18 1914		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.		7. UNDER 1 YEAR MONTHS DAYS 70	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH Randallstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore County General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Meat Cutter		12b. KIND OF BUSINESS OR INDUSTRY Esskay-retired	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Pikesville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1205 Glenback Ave. 21208	
14. FATHER'S NAME FIRST MIDDLE LAST Reinhart Schaefer				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lizabeth Falk					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-01-6455		17. INFORMANT Mrs. Marie Schaefer		ADDRESS 1205 Glenback Ave. Pikesville Maryland 21208			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) METASTATIC GASTRIC CARCINOMA DUE TO, OR AS A CONSEQUENCE OF (c) 2929								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: NO									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 8/6 19 85 to 8/6 19 85 , that (I) (we) last saw the deceased alive on 8/6 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Gary Cohen				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 8/6/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GARY COHEN, MD				22e. ADDRESS 711 W. 40th St. Balt MD. 21211					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/9/85		23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Parkville Baltimore Maryland			
24. FUNERAL DIRECTOR NAME ADDRESS Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, Maryland 21133				25a. DATE REC'D. BY REGISTRAR AUG 12 1985		25b. REGISTRAR'S SIGNATURE John Davidson-Randall			

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 1 7 9 3

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Ella M. Schafer				2a. DATE OF DEATH MONTH 8 DAY 4 YEAR 85				2b. HOUR 3:00 M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH 1 DAY 9 YEAR 16		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Stella Mae's Hospice				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Waitress		12b. KIND OF BUSINESS OR INDUSTRY Restaurant	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Baltimore 13c. CITY OR TOWN Essex				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 20 Walkern Rd. 21221			
14. FATHER'S NAME Frank B. Potterfield MIDDLE LAST				15. MOTHER'S MAIDEN NAME Clara Hardisty MIDDLE LAST					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212 09 9943		17. INFORMANT ADDRESS Charles Schafer, Husband Same					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

metastatic carcinoma

DUE TO, OR AS A CONSEQUENCE OF

(b)

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED: WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from July 29, 1985 to August 4, 1985 , that (1) (we) last saw the deceased alive on August 4, 1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did) (I did not) view the body after death.							
22b. SIGNATURE [Signature]				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) [Signature]				22e. ADDRESS			

23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 8/7/85		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cemetery		23d. LOCATION CITY OR TOWN Baltimore COUNTY Co. STATE Md.	
24. FUNERAL DIRECTOR [Signature] Doboszinski Funeral Home				25a. DATE REC'D. BY REGISTRAR Aug 6 1985		25b. REGISTRAR'S SIGNATURE [Signature]	

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252001

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

21794

REG. NO.

1. DECEASED NAME (LAST OR PRINT) FIRST MIDDLE LAST Sidonie M. SCHEIRE			2a. DATE OF DEATH MONTH DAY YEAR August 30, 1985		2b. HOUR 10:35p		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 2 1895		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 90	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Belgium		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Rossville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
12b. KIND OF BUSINESS OR INDUSTRY		13a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13b. STREET ADDRESS / ZIP CODE 840 Brunswick 21221			
14. FATHER'S NAME FIRST MIDDLE LAST Md. Balto. Essex		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edell Backe		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no		16b. SOCIAL SECURITY NO. 219283033	
17. INFORMANT ADDRESS Thomas Earley 840 Brunswick 21221		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia, bilateral DUE TO, OR AS A CONSEQUENCE OF (c) Ruptured sigmoid diverticulitis, Dehiscence PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) Decubitus ulcer, Alzheimer's disease, chronic cholecystitis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (X) (this hospital) attended the deceased from 7-23 , 19 85 , to 8-30 , 19 85 , that (X) (we) last saw the deceased alive on 8-30 , 19 85 , and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) did (XX) (we) did not view the body after death.		22b. SIGNATURE J.S. Miranda, M.D.		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 8-30-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Miranda		22e. ADDRESS 9000 Franklin Square Dr. 21237		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 9/2/85	
23c. NAME OF CEMETERY OR CREMATORY Security Process		23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville Md.		24. FUNERAL DIRECTOR NAME ADDRESS Connelly Funeral Home 300 Mace Ave. 21221		25a. DATE REC'D. BY REGISTRAR SEP 5 1985	
25b. REGISTRAR'S SIGNATURE John P. Miranda-Randall							

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be associated within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

21795

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EDGAR SCHMIDT			2a. DATE OF DEATH MONTH DAY YEAR 8 1 85		2b. HOUR 7:21 AM
3 SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 11 09 98		6 AGE (IN YEARS LAST BIRTHDAY) 86 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) UNKNOWN	7b. CITIZEN OF WHAT COUNTRY? U.S.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE <i>H. Young</i> MD	
10 CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GOOD SAMARITAN HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Accountant	
12b. KIND OF BUSINESS OR INDUSTRY Retired					

13a. STATE MD			13b. COUNTY BALTIMORE	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 5939 GLENKIRK RD / 21239
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14. FATHER'S NAME FIRST MIDDLE LAST Unknown			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown		
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16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) UNKNOWN	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 26-07-3244	17. INFORMANT ADDRESS Gloria C. Holsclaw, 4949 Benton Heights Ave., Balto., MD 21206
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18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Hypotension DUE TO, OR AS A CONSEQUENCE OF (c) Hemorrhage From Liver Tumor		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION 7/31/85	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED intra-abdominal Hemorrhage	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)
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21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE
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22a. I certify that (I) (this hospital) attended the deceased from 7/31/85 to 8/1/85 that (I) (we) last saw the deceased alive on 7/31/85 and that in my (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.	
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22b. SIGNATURE <i>W. L. Lamm</i> MD.	DEGREE MD.	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 8/4/85
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22d. PHYSICIAN'S NAME (TYPE OR PRINT) W. L. LAMM	22e. ADDRESS Good Samaritan Hospital
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23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 8-5-85	23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Balto., Balto., MD
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24. FUNERAL DIRECTOR'S NAME John C. Miller, Inc., 6415 Belair Rd. Balto., MD 21206	25. DATE REC'D. BY REGISTRAR AUG 2 1985	REGISTRAR'S SIGNATURE <i>John C. Miller</i>
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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death; page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

BP

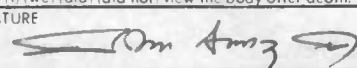
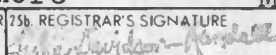


[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like 'REPORT' and 'DATE' are faintly visible.]

246109

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Martin Schwartz			2a. DATE OF DEATH MONTH DAY YEAR 8 27 85		2b. HOUR 7:40 P.M.						
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 11 23 25		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 59		7. IF UNDER 1 YEAR MONTHS DAYS 0 0		8. IF UNDER 24 HRS. HOURS MIN. 0 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Massachusetts		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) F.H.D.		12b. KIND OF BUSINESS OR INDUSTRY O.M.B.C.			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.						13b. COUNTY Baltimore		13c. CITY OR TOWN Catonsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Harry Schwartz						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cecil Unknown Hurwitz					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 030-12-5633		17. INFORMANT 11710 Olde English Dr. Emily Schwartz Apt. E Reston, VA 22090							
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) C.V.A. DUE TO, OR AS A CONSEQUENCE OF (b) H.A.S.H.D. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hrs Yours											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 8/22/85 to 8/27/85 , that (I) (we) lost saw the deceased alive on 8/23/85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE 						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 8/28/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Adnan M. Sonmez M.D.						22e. ADDRESS 500 North Rolling Road 21228					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 8-28-85		23c. NAME OF CEMETERY OR CREMATORY Security Process			23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.			
24. FUNERAL DIRECTOR NAME ADDRESS Cremation Society of Md Inc. Baltimore Md.						25a. DATE REC'D. BY REGISTRAR AUG 30 1985			25b. REGISTRAR'S SIGNATURE 		

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 7 and 8 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

001130



SECRET

235074

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

21797

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Anna M. Scott			2a. DATE OF DEATH MONTH DAY YEAR August 20, 1985		2b. HOUR 4:52 AM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 12 7 1924		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Dundalk	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1958 Inverton Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland		13b. COUNTY Baltimore	13c. CITY OR TOWN Dundalk	13d. STREET ADDRESS / ZIP CODE 1958 Inverton Road 21222	
14. FATHER'S NAME FIRST MIDDLE LAST Thomas Eckert		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Florence McGarry			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-22-6867		17. INFORMANT ADDRESS Diane Anderson Same as 13e	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CA. LUNG</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CARCINOMATOSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>July 1984</u> , 19 <u>85</u> , to <u>July</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>July 6, 1985</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE MTA		DEGREE		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MTA QI		22e. ADDRESS		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/23/1985		23c. NAME OF CEMETERY OR CREMATORY Baltimore National	
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland		24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc. 7922 Wise Avenue Dundalk, Maryland 21222			
25a. DATE REC'D. BY REGISTRAR AUG 21 1985		25b. REGISTRAR'S SIGNATURE Diane Anderson			

MEDICAL CERTIFICATION

99

1

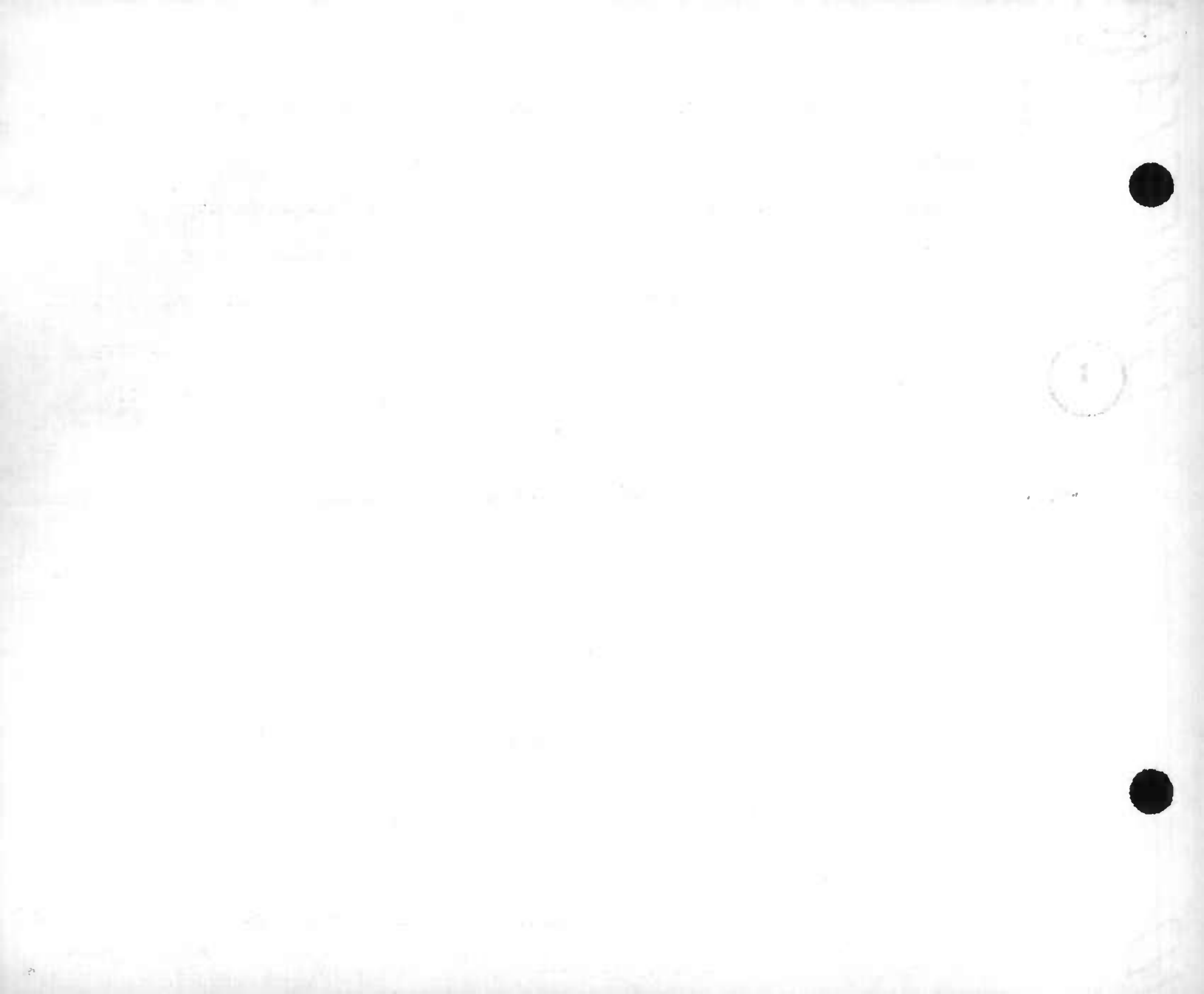
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



235080

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

21798

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) EDNA V. SELF			2a. DATE OF DEATH MONTH DAY YEAR August 19, 1985		2b. HOUR 11:06 AM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR April 11, 1910		6. AGE (IN YEARS LAST BIRTHDAY) 75	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD	
10. CITY OR TOWN OF DEATH TOWSON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. JOSEPH HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland		13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 3812 Parkmont Ave. 21206
14. FATHER'S NAME FIRST MIDDLE LAST George W. Inscow			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anice M. Morris		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 214-24-1707		17. INFORMANT James E. Self Jr. 4010 Chariots Flight Way	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Respiratory Failure**
DUE TO, OR AS A CONSEQUENCE OF
(b) **Stroke**
DUE TO, OR AS A CONSEQUENCE OF
(c) **Arteriosclerosis**

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **Arteriosclerosis**

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE DR. DELEON			22c. DATE SIGNED
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. DELEON			22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Aug 22 1985	23c. NAME OF CEMETERY OR CREMATORY Shiloh Baptist	23d. LOCATION CITY OR TOWN COUNTY STATE Shiloh Virginia
24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc. Baltimore, Maryland		25a. DATE REC'D. BY REGISTRAR AUG 21 1985	25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that a death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please take the permit to the funeral home. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

227044

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

21799
2a. DATE OF DEATH MONTH DAY YEAR 8 12 85 2b. HOUR 12:55 PM

1. DECEASED NAME (TYPE OR PRINT) BEULAH G. SELLMAN			2a. DATE OF DEATH MONTH DAY YEAR 8 12 85			2b. HOUR 12:55 PM	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 10-26-92		6. AGE (IN YEARS LAST BIRTHDAY) 92		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.		
10. CITY OR TOWN OF DEATH Randallstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Balto. County Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) L.P.N.		12b. KIND OF BUSINESS OR INDUSTRY Hospital	
13a. STATE MD.		13b. COUNTY Baltimore	13c. CITY OR TOWN Randallstown	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 10501 Liberty Rd. 21133	
14. FATHER'S NAME FIRST MIDDLE LAST Unk.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unk.				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 212 32 3489		17. INFORMANT ADDRESS Alta Doen Randallstown, MD.			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ATYPICAL PNEUMONIA (INTERSTITIAL) DUE TO, OR AS A CONSEQUENCE OF Dehydration, malnutrition (b) _____ DUE TO, OR AS A CONSEQUENCE OF Severe Anemia (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS, CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **Arterio-sclerotic Cardio-vascular diseases with cardiac amyloidosis.**

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 8/1/85 , 19 85 , to 8/12/85 , 19 85 , that (I) (we) last saw the deceased alive on 8/12/85 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE R.M. Shah M.D.		DEGREE M.D.	22c. DATE SIGNED 8/12/85
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R.M. SHAH.		22e. ADDRESS 8507 LIBERTY RD Randallstown, MD. 21133	

23a. BURIAL, CREMATION, REMOVAL (TYPE) Burial	23b. DATE 8-14-85	23c. NAME OF CEMETERY OR CREMATORY Mt. Lawn Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Randallstown Balto. MD.
24. FUNERAL DIRECTOR NAME ADDRESS Kary W. Haight Sykesville, Md.		25. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE AUG 13 1985 Helia Davidson-Randall	

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ELIZABETH R. SHURE		2a. DATE OF DEATH MONTH DAY YEAR 8-23-85		2b. HOUR 5:35	
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR AUG. 25, 1915		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.	
10. CITY OR TOWN OF DEATH RANDALLSTOWN	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BALTIMORE COUNTY GEN. HOSP.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY AT HOME
13a. STATE MARYLAND		13b. COUNTY BALTO.	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST DR. HARRY W. ROSENTHAL		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST RUTH A. MASBACH			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 215-40-1362		17. INFORMANT MRS. JOANNA COHEN 906 SMOKE TREE RD. BALTO., MD 21208	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF COLON WITH METASTASIS DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE & CONGESTIVE HEART FAILURE					
19a. DATE OF OPERATION 8-12-85		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED INTESTINAL OBSTRUCTION, COLON PERFORATION & SIGMOID COLON		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 7-14 , 19 85 , to 8-23 , 19 85 , that (I) (we) last saw the deceased alive on 8-23 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE [Signature]		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 8-23-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ORLANDO P. CONANAN, M.D.		22e. ADDRESS BCH - RANDALLSTOWN Md. 21133			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE AUG. 25, 1985		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE HEBREW	
23d. LOCATION BALTIMORE		23e. COUNTY MARYLAND			
24. FUNERAL DIRECTOR NAME ADDRESS SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215				25a. DATE REC'D. BY REGISTRAR AUG 27 1985	
				25b. REGISTRAR'S SIGNATURE [Signature]	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use on the burial-transit permit. Then please return carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

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NOTION

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233099

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

2a. DATE OF DEATH MONTH DAY YEAR
August 13, 1985
2b. HOUR
8:30p AM1. DECEASED NAME
(TYPE OR PRINT)
James Sigafoose3. SEX Male 4. RACE White 5. DATE OF BIRTH MONTH DAY YEAR
3 4 1907 6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS
IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland 7b. CITIZEN OF WHAT COUNTRY? USA 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.

10. CITY OR TOWN OF DEATH Rossville 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin square hospital 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired 12b. KIND OF BUSINESS OR INDUSTRY Martins

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland 13c. COUNTY Baltimore 13d. CITY OR TOWN Essex 13e. INSIDE CITY LIMITS? YES ☐ NO ☒ 13f. STREET ADDRESS / ZIP CODE 113101 Eastern Ave. 21220

14. FATHER'S NAME FIRST MIDDLE LAST Charles H Sigafoose 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES ☒ (IF YES, GIVE WAR OR DATES) WW II 16b. SOCIAL SECURITY NO. 218285897 17. INFORMANT ADDRESS John C. Grover 6720 University Dr. 2122018. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1: DEATH WAS CAUSED BY: Cardiorespiratory Arrest
IMMEDIATE CAUSE (a) _____
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Upper Gastrointestinal Hemorrhage

19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 20a. AUTOPSY? YES ☐ NO ☒ 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)21d. INJURY OCCURRED WHILE ☐ AT WORK NOT WHILE ☐ AT WORK 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE22a. I certify that ☒ (this hospital) attended the deceased from August 13, 1985, to August 13, 1985, that ☒ (we) last saw the deceased alive on August 13, 1985, and that in ☒ (our) opinion death occurred on the date and hour and from the causes stated above. ☒ (we) (did) (not) view the body after death.22b. SIGNATURE DEGREE 22c. DATE SIGNED 8/13/85
Dr. Bessman ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Bessman 22e. ADDRESS 9000 Franklin Square Drive 21237

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 23b. DATE 8/16/85 23c. NAME OF CEMETERY OR CREMATORY Holly Hill 23d. LOCATION CITY OR TOWN COUNTY STATE Middle River Balto. Md.

24. FUNERAL DIRECTOR NAME ADDRESS Connelly Funeral Home 300 Mace Ave 21221 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE AUG 16 1985

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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246042

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

21802

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Arlene F. Sigler			2a. DATE OF DEATH MONTH DAY YEAR August 24, 1985		2b. HOUR 5:55P M
3 SEX Female	4 RACE White	5. DATE OF BIRTH MONTH DAY YEAR Nov. 6 1914		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Rossville 21237	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Sq. Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b. KIND OF BUSINESS OR INDUSTRY home
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Baltimore	13c. CITY OR TOWN Chase	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Roy W. Linger			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maud Cottrill		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218 36 2388		17. INFORMANT ADDRESS Charles E. Sigler, Husband Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-respiratory failure					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) Carcinomatosis - Metastatic breast cancer to Liver DUE TO, OR AS A CONSEQUENCE OF (c) Cervical carcinoma					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a: Persistent vesico-vaginal fistula secondary to irradiation					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (this hospital) attended the deceased from July 23, 1985 to August 24, 1985 , that (we) lost show the deceased alive on August 24, 1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>R. S. Miranda</i>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 8-24-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Reynaldo Miranda, MD		22e. ADDRESS 9000 Franklin Square Drive 21237			
23a. BURIAL, CREMATION, REMOVAL (TYPE) Burial		23b. DATE 8/27/85		23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park	
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.		23e. DATE REC'D. BY REGISTRAR AUG 27 1985			
24. FUNERAL DIRECTOR <i>Edward J. Blyskal</i> Edward J. Blyskal		25. REGISTRAR'S SIGNATURE <i>John Boudreau</i> John Boudreau			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be returned within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filed in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

21803
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
LUCINDA SILVER
2a. DATE OF DEATH MONTH DAY YEAR
8/6/85
2b. HOUR
7:30p M

3. SEX Female 4. RACE White 5. DATE OF BIRTH MONTH DAY YEAR
Aug. 4, 1899 6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS
IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD 7b. CITIZEN OF WHAT COUNTRY? USA 8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE COUNTY MD.

10. CITY OR TOWN OF DEATH TOWSON 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
6701 N. CHARLES ST GBMC 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sales 12b. KIND OF BUSINESS OR INDUSTRY Real Estate

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE MD 13b. COUNTY Balto. 13c. CITY OR TOWN Balto. 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ 13e. STREET ADDRESS / ZIP CODE 101 Murdock Rd., 21212

14. FATHER'S NAME FIRST MIDDLE LAST John E. Silver 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rose G. Stifler

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No (IF YES, GIVE WAR OR DATES) 16b. SOCIAL SECURITY NO. 218 14 5367 17. INFORMANT ADDRESS Mary S. Baum, Same

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (b) stating the underlying cause last. (b) METASTATIC CARCINOMA
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 20a. AUTOPSY? YES ☐ NO ☒ 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED (WHERE ☐ NOT WHERE ☐ AT HOME ☐ AT WORK ☐ 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

21a. I certify that (I) (this hospital) attended the deceased from 7/30 19 85 to 8/6 19 85, that (I) (we) last saw the deceased alive on 8/6 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22a. SIGNATURE 22b. PHYSICIAN'S NAME (TYPE OR PRINT) DR. A MALOUF 22c. DATE SIGNED Aug 6, 1985
DEGREE MD ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒

22d. ADDRESS GBMC

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 23b. DATE 8/9/85 23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley 23d. LOCATION CITY OR TOWN COUNTY STATE Balto. County MD

24. FUNERAL DIRECTOR NAME Henry W. Jenkins & Sons Co. 25a. DATE REC'D. BY REGISTRAR AUG 7 1985 25b. REGISTRAR'S SIGNATURE
4905 York Road Balto., MD 21212

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner will be notified of this.

2011



LUCINDA SILVER

101 N. 1st St. Baltimore, MD 21202

BALTIMORE COUNTY

101 N. 1st St. Baltimore, MD 21202

101 N. 1st St. Baltimore, MD 21202

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BALTIMORE COUNTY

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101 N. 1st St. Baltimore, MD 21202

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 85-21804							
1. DECEASED NAME (TYPE OR PRINT) CHARLES ROBERT SIMMONS						2a. DATE OF DEATH MONTH DAY YEAR 9/18/85		2b. HOUR 12:25 AM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10 1 21		6. AGE (IN YEARS LAST BIRTHDAY) 63		6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH Baltimore County		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Ivy Hall Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret.-Bus Driver		12b. KIND OF BUSINESS OR INDUSTRY McMahon Bus Company	
13a. STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Charles Henry Simmons			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eleanor Gartling			13e. STREET ADDRESS 4208 Kenwood Ave. 21206			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. 218-18-7245		17. INFORMANT ADDRESS Maurice L. Simmons 3406 E. Balto.St. 21224				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: (IMMEDIATE CAUSE (a)) Cancer Metastasis									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) CA Lung									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE [Signature]			22c. NAME OF PHYSICIAN (TYPE OR PRINT) Dr. Firozvi (284-2400)			22d. ADDRESS 223 Eastern Blvd. Baltimore, Maryland			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 8-18-85		23c. NAME OF CEMETERY OR CREMATORY Westview Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland		
24. FUNERAL DIRECTOR NAME Lassahn Funeral Home			24b. ADDRESS 7401 Belair Rd BALTO. MD. 21236		25a. DATE REC'D. BY REGISTRAR 9/28/85		25b. REGISTRAR'S SIGNATURE [Signature]		

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1. The first part of the report is a general description of the project and its objectives. It includes a brief history of the project and a statement of the problem to be solved. The second part of the report is a detailed description of the methodology used in the study. This includes a description of the data collection methods, the statistical methods used for data analysis, and the experimental procedures used to test the hypotheses. The third part of the report is a discussion of the results of the study. This includes a description of the findings, a comparison of the results with previous studies, and a discussion of the implications of the findings. The fourth part of the report is a conclusion and a list of references. The conclusion summarizes the main findings of the study and provides a final statement on the project. The references list the sources of information used in the study.

2. The first part of the report is a general description of the project and its objectives. It includes a brief history of the project and a statement of the problem to be solved. The second part of the report is a detailed description of the methodology used in the study. This includes a description of the data collection methods, the statistical methods used for data analysis, and the experimental procedures used to test the hypotheses. The third part of the report is a discussion of the results of the study. This includes a description of the findings, a comparison of the results with previous studies, and a discussion of the implications of the findings. The fourth part of the report is a conclusion and a list of references. The conclusion summarizes the main findings of the study and provides a final statement on the project. The references list the sources of information used in the study.

242028

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

21805

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Paul R Skaggs			2a. DATE OF DEATH MONTH DAY YEAR August 26, 1985			2b. HOUR 11:58p _M						
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov 17, 1903		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.						
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Warehouse Dist.		12b. KIND OF BUSINESS OR INDUSTRY B. G. & E.				
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 6004 Glenoak Avenue 21214		
14. FATHER'S NAME FIRST MIDDLE LAST John Skaggs				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elvrie (Unknown)								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW I		17. INFORMANT Mrs. Lillian M. Skaggs same as # 13						

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Myocardial Infarction		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
DUE TO, OR AS A CONSEQUENCE OF			
(c)			

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from August 26, 1985, to August 27, 1985, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on August 27, 1985, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (I/we) (did) (did not) view the body after death.							
22b. SIGNATURE K. Mahoney, M.D.				DEGREE MD.		22c. DATE SIGNED August 27, 1985	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) K. Mahoney, M.D.				22e. ADDRESS 9000 Franklin Square Drive 21237			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/31/85		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland	
24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc. 5305 Harford Road 21214				25a. DATE REC'D BY REGISTRAR AUG 28 1985			
				25b. REGISTRAR'S SIGNATURE J. Mahoney			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

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and Virginia

Religious
Latter-day
Saints

For



FOR FIDELITY
AND
TRUTH

Initial

Vol. 1, 1907

Branch of the Church

at

St. Louis

St. Louis, Mo.

St. Louis, Mo.

St. Louis, Mo.

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228026

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Marvin Sklar			2a. DATE OF DEATH MONTH 8 DAY 10 YEAR 85			2b. HOUR 2:30 P.M.						
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH JUNE DAY 28 YEAR 1927		6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS. HOURS 0 MIN. 0		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.						
10. CITY OR TOWN OF DEATH PIKESVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4725 BELLE FORTE RD. (21208)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MERCHANT		12b. KIND OF BUSINESS OR INDUSTRY RETAIL				
13a. STATE MARYLAND				13b. COUNTY BALTIMORE		13c. CITY OR TOWN PIKESVILLE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4725 BELLE FORTE RD. (21208)		
14. FATHER'S NAME FIRST HARRY MIDDLE SKLAR LAST SKLAR				15. MOTHER'S MAIDEN NAME FIRST YETTA MIDDLE BASSUK LAST BASSUK								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 219-10-4633		17. INFORMANT ADDRESS Mrs. Sylvia Sklar 4725 Belle Forte Rd. (21208)						

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Non small cell carcinoma of lungAPPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH**8 months**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 7 19 85 to 8/10 19 85 , that (I) (we) last saw the deceased alive on 8/10 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Dr. M. L. Lichtentfeld M.D.				DEGREE		22c. DATE SIGNED 8/10/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Lichtentfeld				22e. ADDRESS 2360 Joppa Rd. Baltimore., Md. (21004)			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 8/11/85		23c. NAME OF CEMETERY OR CREMATORY FORBAND CEM.		23d. LOCATION CITY OR TOWN ROSEDALE, BALTIMORE, MD. COUNTY STATE	
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS. 6010 REISTERSTOWN RD. BALTIMORE., MD (21215)				25a. DATE REC'D. BY REGISTRAR AUG 13 1985		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked for item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a separate report filed.

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(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy of Part 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item #1 film #G606

1- STATE
FOR 8/16/85 jps
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

21807

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Marie S. Slater				2a. DATE OF DEATH MONTH DAY YEAR August 4, 1985		2b. HOUR 3:55P M	
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR 5 31 1904		6 AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 81	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10 CITY OR TOWN OF DEATH Rossville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Edgemere		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST John Schaff		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Wilhelmenia Weiss		13e. STREET ADDRESS / ZIP CODE 3208 River Drive Rd. 21219			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-07-6159		17 INFORMANT ADDRESS Diane C. Stefan Same as 13e			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Pulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of Lung with Metastasis DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (this hospital) attended the deceased from August 1, 1985 to August 4, 1985 , that (we) last saw the deceased alive on August 4, 1985 , and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (not) view the body after death.							
22b. SIGNATURE Geoffrey D. Sloan				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 8/4/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Geoffrey D. Sloan				22e. ADDRESS 9000 Franklin Square Dr. 21237			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/7/85		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland	
24. FUNERAL DIRECTOR NAME ADDRESS Duda-Ruck, Inc 7922 Wise Ave Baltimore, Maryland 21222				25a. DATE REC'D. BY REGISTRAR AUG 7 1985			
				25b. REGISTRAR'S SIGNATURE John Davidson			

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234034

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Rosalie J. Slifer		7a. DATE OF DEATH MONTH DAY YEAR 8-13-85		2b. HOUR 2:20 pm	
3. SEX FEMALE		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 3-30-17	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7c. CITIZEN OF WHAT COUNTRY? U.S.A.		8. AGE (IN YEARS LAST BIRTHDAY) 68 IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
10. CITY OR TOWN OF DEATH Parkville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VALLEY VIEW NURSING HOME		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. CITY County MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home			
13a. STATE MD.		13b. COUNTY Baltimore		13c. CITY OR TOWN Middle River	
14. FATHER'S NAME FIRST MIDDLE LAST James Martin		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Kathleen Gregory		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 233 42 0499		17. INFORMANT ADDRESS Sidney R. Johnson (Son) Right Elevator Dr. 21220	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of lung DUE TO, OR AS A CONSEQUENCE OF (b) old stroke DUE TO, OR AS A CONSEQUENCE OF (c) 		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **Recurrent thrombosis - Trousseau's**

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 8/29/85 to 8/13/85 , that (I) (we) lost saw the deceased alive on 8/29/85 , and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE Vuone Nguyen		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/14/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) VUONE NGUYEN		22e. ADDRESS 6331 Belair Rd Balto 21206					

23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 8/15/85		23c. NAME OF CEMETERY OR CREMATORY Holly Hill Memorial Garden		23d. LOCATION CITY OR TOWN COUNTY Baltimore County, Md.	
24. FUNERAL DIRECTOR Przedzinski Funeral Home PA 1407 Old Eastern Ave.				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE AUG 16 1985	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it must be filed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

21809

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LOUISE SLITZER			2a. DATE OF DEATH MONTH DAY YEAR 8-20-85		2b. HOUR 11:40 AM		
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 10-15-96		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore COUNTY MD.	
10. CITY OR TOWN OF DEATH Essex		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) RIVERVIEW NURSING CENTRE				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Albert J. Biscoe		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Louisa Grease		16. STREET ADDRESS / ZIP CODE 518 N. Decker Ave. 21205			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 213-34-2259A		17. INFORMANT ADDRESS Albert L. Slitzer 3208 Eastern Ave. 21224			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs.	
DUE TO, OR AS A CONSEQUENCE OF (b) Coronary artery disease		15 years	
DUE TO, OR AS A CONSEQUENCE OF (c)			

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from June 22, 1981 to Aug. 20, 1985 , that (I) (we) last saw the deceased alive on Aug. 20, 1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE M. Ramsey M.D.				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/21/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MORRIS KAINNESS, M.D.				22e. ADDRESS 1105 Old Eastern Ave. Balto, Md. 21224			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-23-85		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland	
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24. FUNERAL DIRECTOR NAME Sassah F. H.		25a. DATE REC'D. BY REGISTRAR 8/26/85		25b. REGISTRAR'S SIGNATURE John Davidson-Randall	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

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(VR A15 ME (5))
20M 4/82

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

21810

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Frederick Richard Hunter Small				2a. DATE KNOWN OF DEATH ESTIMATED August 29, 85				2b. HOUR 5 PM	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR June 17 1901	6. AGE (IN YEARS) (LAST BIRTHDAY) 84 YRS.	IF UNDER 1 YR. MONTHS DAYS 0 0	IF UNDER 24 HRS. HOURS MIN. 0 0	7c. DATE PRONOUNCED DEAD August 29, 85		7d. HOUR 5 PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County			
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Joseph Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Insurance		12b. KIND OF BUSINESS OR INDUSTRY Insurance	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Monkton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1445 Monkton Rd., 21111	
14. FATHER'S NAME FIRST MIDDLE LAST Frederick Small				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jennie Agnes McCausland					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-03-2273		17. INFORMANT ADDRESS Julia D. Small, 1445 Monkton Rd., 21111			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. ASCD (b) ASCD DUE TO, OR AS A CONSEQUENCE OF (c) ASCD APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden 2 to 3 hrs									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .									
ACTUAL SIGNATURE <i>Charles F. O'Donnell</i>				TITLE (SPECIFY) Deputy		MEDICAL EXAMINER		DATE SIGNED 8/29/85	
EXAMINER'S NAME (TYPE OR PRINT) Charles F. O'Donnell, M.D.				ADDRESS 7501 York Rd., 21204					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/31/85		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Woodlawn Balto. Md.			
24. FUNERAL DIRECTOR NAME ADDRESS J. E. Lowell Lemmon, 10 W. Padonia Rd.						25a. DATE REC'D. BY REGISTRAR AUG 30 1985		25b. REGISTRAR'S SIGNATURE <i>Jane Davidson-Randall</i>	



241118

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Elmo A. SMERO			2a. DATE OF DEATH MONTH DAY YEAR August 24, 1985		2b. HOUR 10:35p_M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 5 24 1924		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS 61 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Essex	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Scale Repair Tech.-Beth. Steel		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland		13b. COUNTY Baltimore	13c. CITY OR TOWN Dundalk	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Alfonso M. Smero		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Agnes J. Plonk		16. STREET ADDRESS / ZIP CODE 7251 Meadow Lane 21222	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 219-16-8702		17. INFORMANT ADDRESS Leona F. Smero Same as 13e	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Interstitial pneumonitis DUE TO, OR AS A CONSEQUENCE OF (b) Uremia DUE TO, OR AS A CONSEQUENCE OF (c) Systemic vasculitis PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I, this hospital) attended the deceased from 7-22 , 19 85 , to 8-24 , 19 85 , that XX (we) last saw the deceased alive on 8-24 , 19 85 , and that in XX (our) opinion death occurred on the date and hour and from the causes stated above. XX (we) (did) (did not) view the body after death.					
22b. SIGNATURE Gregory R. Leib, M.D.		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 8-24-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Gregory R. Leib, M.D.		22e. ADDRESS 9000 Franklin Square Drive 21237			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/28/1985		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland		23e. DATE REC'D. BY REGISTRAR AUG 27 1985			
24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc.		ADDRESS 7922 Wise Avenue Dundalk, Maryland 21222		25b. REGISTRAR'S SIGNATURE Jane Davidson	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be reprinted by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please reattach carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified on page 3.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

21812

1- FOR
STATE
REGISTRAR

235079

1. DECEASED NAME (TYPE OR PRINT) Anna Caroline SMITH			2a. DATE OF DEATH MONTH DAY YEAR August 20, 1985		2b. HOUR 1:15a M
3 SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR July 23 1890		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 95	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
11. CITY OR TOWN OF DEATH Rossville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Sq. Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY at home
13a. STATE Md.		13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST John		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 214-74-3998		17. INFORMANT ADDRESS Donald A. Smith 5928 Hillen Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Septicemia and Metabolic Acidosis DUE TO, OR AS A CONSEQUENCE OF (c) _____ CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (he) (this hospital) attended the deceased from July 24 , 19 85 , to August 20 , 19 85 that (we) last saw the deceased alive on August 20 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (he) (we) (did) (did not) verify this after death.					
22b. SIGNATURE Roger Moushabek, M.D.		22c. ADDRESS 9000 Franklin Sq. Dr., 21237		22d. DATE SIGNED 8/20/85	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-23-85		23c. NAME OF CEMETERY OR CREMATORY Meadwridge	
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. 5305 Harford Rd.		23d. LOCATION CITY OR TOWN COUNTY STATE Howard Md.		25a. DATE REC'D. BY REGISTRAR AUG 21 1985	
				25b. REGISTRAR'S SIGNATURE <i>Richard R. Ruck</i>	

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• BK

235132

FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

21813

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GENEVIEVE T. SMITH			2a. DATE OF DEATH MONTH DAY YEAR Aug. 17, 85		2b. HOUR MIN. 9:15 P		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 19, 1897		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 88 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore Co. MD.	
10. CITY OR TOWN OF DEATH Randallstown,		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Balto Co. Gen. Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk		12b. KIND OF BUSINESS OR INDUSTRY Laundry	
13a. STATE Md..		13b. COUNTY A. A. Co.		13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST James - Carroll		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dora - Einoff		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 219-10-0239 A	
17. INFORMANT Carroll Smith		18. ADDRESS same as 13		19. DATE OF OPERATION Aug. 15, 1985		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from Aug. 15, 1985 to Aug. 17, 1985 , that (I) (we) lost saw the deceased alive on Aug. 17, 1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE Sharon Gounotabed, M.D.		22c. DATE SIGNED 8-17-85		22d. PHYSICIAN'S NAME (TYPE OR PRINT) GHASSEM POURMOTABED	
22e. ADDRESS Balto. Co. Gen. Hospital		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-20-85		23c. NAME OF CEMETERY OR CREMATORY Balto. Nat. Cem	
23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville Balto. Md.		24. FUNERAL DIRECTOR NAME McCully F.H. 3204 Mountain Rd. Pasadena, Md.		25a. DATE REC'D. BY REGISTRAR AUG 21 1985		25b. REGISTRAR'S SIGNATURE [Signature]	



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Jerlean H. Smith			2a. DATE OF DEATH MONTH DAY YEAR August 23, 1985			2b. HOUR M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 21, 1927		6. AGE (IN YEARS LAST BIRTHDAY) 58		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH 21220 Middle River		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 103 Propeller Drive				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Middle River		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 103 Propeller Dr. 21220	
14. FATHER'S NAME FIRST MIDDLE LAST George Harper				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bertha Ketterman					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 234 40 3251		17. INFORMANT Roy B. Smith, Sr. Husband				ADDRESS Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Non-Hodgkins Lymphoma								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 14 yrs.	
DUE TO, OR AS A CONSEQUENCE OF (b) _____									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>Aug 17</u> , 19 <u>85</u> , to <u>Aug 23</u> , 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>Aug 17</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Sheldon C. Kravitz, M.D.						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/25/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SHELDON C. KRAVITZ, M.D.						22e. ADDRESS 201 E. University Pkwy			
23a. BURIAL, CREMATION, REMOVAL Burial			23b. DATE 8/26/85		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co., Md.		
24. FUNERAL DIRECTOR Wladzinski Funeral Home PA 140						25a. DATE REC'D. BY REGISTRAR AUG 27 1985		25b. REGISTRAR'S SIGNATURE John Davidson-Rodan	

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Octavia M. Smith</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>August 27, 1985</i>		2b. HOUR <i>7:35 AM</i>	
3. SEX <i>Female</i>	4. RACE <i>Black</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>2 21 96</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <i>89 6 6</i>	IF UNDER 1 YEAR IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>New Orleans, LA</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore County</i> MD.		
10. CITY OR TOWN OF DEATH <i>Towson</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Stella Maris</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Scamstress</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Maryland</i>		13b. COUNTY <i>Baltimore</i>	13c. CITY OR TOWN <i>Baltimore</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <i>4133 Alameda 21218</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Charles Peters</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Pauline Planchard</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>216-12-8749</i>		17. INFORMANT ADDRESS <i>Lorraine Moore 4133 The Alameda Facility</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>PVD Peripheral Vasc. Disease</i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) <i>ASCVD Arteriosclerotic cardiovascular disease</i>						
DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <i>9/24</i> , 19 <i>81</i> , to <i>8/27</i> , 19 <i>85</i> , that (I) (we) last saw the deceased alive on <i>8/26</i> , 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>K R Faulkner MD</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>08/27/85</i>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Kendall R. Faulkner</i>				22e. ADDRESS <i>Stella Maris</i>		
23a. BURIAL, CREMATION, REMOVAL 13a. BURIAL		23b. DATE <i>8/30/85</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Arbutus Memorial Fk, Arbutus Md.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE
24. FUNERAL DIRECTOR NAME <i>Wm C March F/E Inc.</i>				25a. DATE REC'D. BY REGISTRAR <i>AUG 29 1985</i>		25b. REGISTRAR'S SIGNATURE <i>K. Davidson-Randall</i>

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

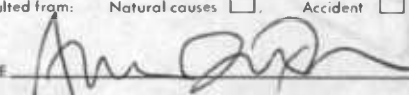
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY. PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PW-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

 1- FOR
 STATE
 REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) DONALD				2a. DATE KNOWN OF DEATH EST: <input checked="" type="checkbox"/> 8 13 1985				2b. HOUR M	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 10/21/ 42	6. AGE (IN YEARS LAST BIRTHDAY) 42 YRS.	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN.	7c. DATE PRONOUNCED DEAD 8 14 1985		7d. HOUR 8:10 P	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD			
10. CITY OR TOWN OF DEATH Essex		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2401 Beech Ave.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Pipefitter-Balvo.		12b. KIND OF BUSINESS OR INDUSTRY St. Hous.	
13a. STATE Md.		13b. COUNTY Balto.		13c. CITY OR TOWN Essex		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 2401 Beach Ave. 21221	
14. FATHER'S NAME FIRST MIDDLE LAST Donald Smoot Sr.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ruth Joins					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO. 217384163		17. INFORMANT ADDRESS Kathaleen Smoot 2401 Beach Ave 21			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wound of head (handgun) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? Head Only YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 8-13- 1985		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Self-inflicted.					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 2401 Beech Ave. Baltimore MD					
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .									
ACTUAL SIGNATURE 				TITLE (SPECIFY) M.D. Assistant				DATE SIGNED 8-15-85	
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.				ADDRESS 111 Penn St., Balto., MD 21201					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/19/85		23c. NAME OF CEMETERY OR CREMATORY holly hill		23d. LOCATION CITY OR TOWN COUNTY STATE 111 Penn St. Balto. Md.			
24. FUNERAL DIRECTOR NAME ADDRESS Connely Funeral Home 300 Mace Ave. 21221				25a. DATE REC'D. BY REGISTRAR AUG 16 1985					

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85

21817

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Mabel E. Smythe			2a. DATE OF DEATH MONTH DAY YEAR August 16, 1985		2b. HOUR 9:25 a.m.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 6 5 01		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.		
10. CITY OR TOWN OF DEATH Rossville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Homemaking				
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN		
14. FATHER'S NAME FIRST MIDDLE LAST William W. Linzey		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Agnes Angel		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. 218-52-2571		17. INFORMANT ADDRESS 21220 Raymond C. Smythe, Jr. 1123 Cold Spring		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a <u>Pacemaker implant, non-insulin diabetic</u>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that <input checked="" type="checkbox"/> (this hospital) <u>August 13</u> , 19 <u>85</u> , to <u>August 16</u> , 19 <u>85</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>August 16</u> , 19 <u>85</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (we) did not view the body after death.						
22b. SIGNATURE <u>Gary Johnson</u>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>8/16/85</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Gary Johnson</u>		22e. ADDRESS <u>9000 Franklin Square Drive 21237</u>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>8-20-85</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>		
23d. LOCATION CITY OR TOWN <u>Baltimore</u>		COUNTY <u>Maryland</u>		STATE		
24. FUNERAL DIRECTOR NAME <u>Tarsahn General Home</u>		ADDRESS <u>7401 Blair Rd</u>		25a. DATE REC'D. BY REGISTRAR <u>AUG 22 1985</u>		
25b. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u>						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal certificate should be notified at once.

BP

3-10-43

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Mrs. Loretta Ann Spencer			2a. DATE OF DEATH MONTH DAY YEAR August 8 1985			2b. HOUR M 10			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR December 13 1892		6. AGE (IN YEARS LAST BIRTHDAY) 92 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH Villa Nova		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Katherine Robb Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Pikesville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4101 Lowell Drive 21208	
14. FATHER'S NAME FIRST MIDDLE LAST John Denkin					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Johanna Michels				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-40-5344		17. INFORMANT NAME ADDRESS Mr. Joseph D. Spencer 21207 3608 Durley Lane Baltimore Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) Ascaris DUE TO, OR AS A CONSEQUENCE OF (c) Chronic brain syndrome Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days 10 yrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: chronic brain syndrome									
19a. DATE OF OPERATION none		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 712 58 8/8 85					
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 8/6 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE R. M. Fildner				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 8/9/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 08-12-85		23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Pikesville Baltimore Maryland			
24. FUNERAL DIRECTOR NAME ADDRESS Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, Maryland 21133				25. DATE REC'D. BY REGISTRAR Aug 12 1985					
				26. REGISTRAR'S SIGNATURE John Davidson-Randall					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 checked, any injury, or other traumatic event, the medical examiner must be notified of once.

336131

James, Lorraine Ann, 1935

James, Lorraine Ann, 1935

James, Lorraine Ann, 1935

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85

21819

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WALTER F. SPENCER			2a. DATE OF DEATH MONTH DAY YEAR 8 19 85		2b. HOUR 2005 M
3. SEX MALE	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 12 28 24		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Randallstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore Co. Gen. Hosp		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Service MAN	12b. KIND OF BUSINESS OR INDUSTRY Propane	
13a. STATE md		13b. COUNTY Balto	13c. CITY OR TOWN Owings Mills	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Robey Spencer		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Freda Zimmer		16. ADDRESS 121 Cedarvale Rd. 21117	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. 220-16-0082		17. INFORMANT Ruth M. Spencer	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) REFRACTORY VENTRICULAR FIBRILLATION DUE TO, OR AS A CONSEQUENCE OF (b) CARDIOMYOPATHY DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **HEMOPHYSIS ADULT ONSET DIABETES MELLITUS S/P CPR**

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, EARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE Hafeez A Syed	DEGREE MD	22c. ADDRESS BALTIMORE COUNTY GEN HOSP.	22d. DATE SIGNED 8/19/85
22e. PHYSICIAN'S NAME (TYPE OR PRINT) HAFAEZ A SYED		22f. ADDRESS BALTIMORE COUNTY GEN HOSP.	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE Aug. 21, 1985	23c. NAME OF CEMETERY OR CREMATORY Evergreen Mem. Gdn.	23d. LOCATION CITY OR TOWN COUNTY STATE Finksburg Carroll MD
24. FUNERAL DIRECTOR NAME H. J. Eichardt		25a. DATE REC'D. BY REGISTRAR AUG 22 1985	25b. REGISTRAR'S SIGNATURE J. K. Miller

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of such.

1. The first of these is the
 fact that the population of
 the country is increasing
 rapidly. This is due to a
 number of factors, including
 a high birth rate and a
 falling death rate. The
 result is that the number of
 people living in the country
 is growing at a rapid rate.
 This has a number of
 implications for the future
 of the country.

One of the main problems
 facing the country is the
 shortage of land. The
 population is increasing
 rapidly, and the amount of
 land available for farming
 is decreasing. This is
 due to a number of factors,
 including the fact that the
 land is being used for
 other purposes, such as
 housing and industry.

Another problem is the
 shortage of water. The
 population is increasing
 rapidly, and the amount of
 water available for drinking
 and irrigation is decreasing.
 This is due to a number of
 factors, including the fact
 that the water is being
 used for other purposes,

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Marguerite G. Spinner			2a. DATE OF DEATH MONTH DAY YEAR August 4, 1985		2b. HOUR A. M. 1:10		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 24 1891		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 94	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.Y.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Glenarm		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5902 Glenarm Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY -	
13a. STATE Md.		13b. COUNTY Baltimore		13c. CITY OR TOWN Glenarm		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Luke Glancy		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret McQueeney		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 078-03-6619	
17. INFORMANT Clarence Spinner (son)		18. ADDRESS same address		19. STREET ADDRESS 5902 Glenarm Ave.		20. ZIP CODE 21057	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause lost.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (c)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) <u>did</u> (not) attend the deceased from <u>March</u> 19 <u>83</u> to <u>August 4</u> 19 <u>85</u> , that (I) <u>did</u> (not) last saw the deceased alive on <u>11/2</u> 19 <u>83</u> , and that in my (my) opinion death occurred on the date and hour and from the causes stated above, (I) <u>did</u> (not) view the body after death.							
22b. SIGNATURE <i>Dr. Charles Hatton</i>		DEGREE <i>MD</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8-5-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Charles Hatton				22e. ADDRESS Osler Bldg.			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 8/4/85		23c. NAME OF CEMETERY OR CREMATORY St. Patrick Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Lockport Niagara N.Y.	
24. FUNERAL DIRECTOR'S NAME Schimunek Funeral Home Inc.				25a. DATE REC'D. BY REGISTRAR AUG 6 1985			
25b. ADDRESS 9705 Belair Rd., Balto. Md. 21236				25c. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

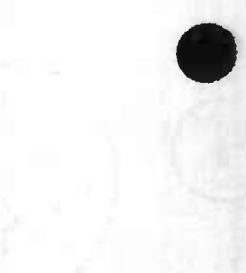
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1. The first part of the document is a list of items that were received from the donor. These items include a variety of books, records, and other materials. The list is organized in chronological order, starting with the earliest items and ending with the most recent. Each item is described in detail, including its title, author, and any other relevant information. The list is followed by a section that provides a summary of the total number of items received and a breakdown of the types of materials.

2. The second part of the document is a list of items that were received from the donor. These items include a variety of books, records, and other materials. The list is organized in chronological order, starting with the earliest items and ending with the most recent. Each item is described in detail, including its title, author, and any other relevant information. The list is followed by a section that provides a summary of the total number of items received and a breakdown of the types of materials.

3. The third part of the document is a list of items that were received from the donor. These items include a variety of books, records, and other materials. The list is organized in chronological order, starting with the earliest items and ending with the most recent. Each item is described in detail, including its title, author, and any other relevant information. The list is followed by a section that provides a summary of the total number of items received and a breakdown of the types of materials.

4. The fourth part of the document is a list of items that were received from the donor. These items include a variety of books, records, and other materials. The list is organized in chronological order, starting with the earliest items and ending with the most recent. Each item is described in detail, including its title, author, and any other relevant information. The list is followed by a section that provides a summary of the total number of items received and a breakdown of the types of materials.



256028

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) ARDITH SPITZNAS			2a. DATE OF DEATH MONTH DAY YEAR 8-25-85			2b. HOUR 8³⁰ A.M.			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 7 25 41		6 AGE (IN YEARS LAST BIRTHDAY) 44 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N, Dakota		7b. CITIZEN OF WHAT COUNTRY? U.S.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.			
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) STELLA MARIS HOSPICE				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sec'y		12b. KIND OF BUSINESS OR INDUSTRY School	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Md.		13b. COUNTY		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 6905 Banbury Road 21239	
14 FATHER'S NAME FIRST MIDDLE LAST Arthur Kilgore					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lila Becker				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 331-34-9003		17 INFORMANT ADDRESS Mr. Raymond J. Spitznas - Same/as #13					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PANCREATIC CANCER DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 7-30 , 19 85 , to 8-25 , 19 85 , that (I) (we) last saw the deceased alive on 8-25 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE K.R. Faulkner MD						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8-25-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kendall R. Faulkner, M.D.						22e. ADDRESS Stella Maris Hospice 2300 Dulany Valley Rd. - Towson, MD 21204			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal			23b. DATE 8/25/85		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
24 FUNERAL DIRECTOR NAME Anatomy Board						ADDRESS Balto., Md.		25a. DATE RECD. BY REGISTRAR AUG 29 1985	
						25b. REGISTRAR'S SIGNATURE John Davidson-Rendell			

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this certificate from the file and return it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, a medical examiner must be notified of cause.

328058



White

2000

100% COTTON 45/1 W

224042

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

21822

FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) VIRGINIA C STANCILL			2a. DATE OF DEATH MONTH 08 DAY 05 YEAR 85			2b. HOUR M				
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH 02 DAY 16 YEAR 06		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS		7. IF UNDER 1 YEAR MONTHS 05 DAYS 05 HOURS 05 MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CO MD.				
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST JOSEPH HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ACCOUNT REPRESENTATIVE BANK				
13a. STATE MD			13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTO		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 8432 A GREENWAY RD 21234	
14. FATHER'S NAME FIRST HENRY MIDDLE M. LAST CARTER			15. MOTHER'S MAIDEN NAME FIRST HARRIET MIDDLE STURGEON LAST STURGEON							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 218-14-1078		17. INFORMANT ADDRESS NANCY H. EMBERSON JACKSONVILLE, FLORIDA					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Severe Chronic obstructive pulmonary disease

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH*10 yr.*

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

Severe Coronary Artery Disease with Ischemic Myocardium

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>August 5, 1985</u> to <u>August 5, 1985</u> , that (I) (we) last saw the deceased alive on <u>August 5, 1985</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE <i>Samuel O'Mansky</i>				DEGREE MD		22c. DATE SIGNED Aug 5, 1985	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SAMUEL O'MANSKY				22e. ADDRESS 8405A LOCH RAVEN BLVD.			

23a. BURIAL, CREMATION, REMOVAL CREMATION		23b. DATE AUG. 7, '85		23c. NAME OF CEMETERY OR CREMATORY GREEN MOUNT CEMETERY		23d. LOCATION CITY OR TOWN BALTIMORE, MARYLAND COUNTY STATE	
24. FUNERAL DIRECTOR NAME WILLIAM E. JOHNSON ADDRESS 8521 LOCH RAVEN BLVD.				25. DATE OF REGISTRATION AUG 7 1985 REGISTRAR'S SIGNATURE <i>[Signature]</i>			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

246105

1 - FOR
STATE
REGISTRAR

STEPAN

BARBARA K.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

21323

1. DECEASED NAME (TYPE OR PRINT) Barbara Stepan			2a. DATE OF DEATH MONTH DAY YEAR 08-27-85		2b. HOUR 6:15 PM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 03 12 1892		6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Heritage Meridian		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) House wife	12b. KIND OF BUSINESS OR INDUSTRY —	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY ---		13c. CITY OR TOWN City	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST JOSEPH --- REZAC		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELIZABETH ---			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) UNKNOWN		16b. SOCIAL SECURITY NO. N/A		17. INFORMANT ADDRESS Jerry STEPAN 3550 JUNEWAY 21213	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) COMPLETE HEART BLOCK DUE TO, OR AS A CONSEQUENCE OF (b) A.S.C.V.D DUE TO, OR AS A CONSEQUENCE OF (c) — Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 month YEARS.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: PNEUMONIA DECUBITUS ULCER.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE B. C. Veneracion Jr		DEGREE		22c. DATE SIGNED 8/27/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) B. C. VENERACION JR MD		22e. ADDRESS 3461 Dundalk Ave Sg 66 21222 MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 8/29/85	23c. NAME OF CEMETERY OR CREMATORY BOHEMIAN NATIONAL		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO MD	
24. FUNERAL DIRECTOR Geoffrey S. S.		ADDRESS 1211 Chesapeake		25a. DATE REC'D. BY REGISTRAR AUG 29 1985	25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall

MEDICAL CERTIFICATION

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 21 is marked as item 18 showing any injury, an other traumatic event, the medical examiner must be notified of age.)

22120

2

228162

FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. XC33 721 479

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
EARL STEWART					AUGUST 10, 1985				11:30a M
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS		
MALE	BLACK	OCT. 25, 1924		60	MONTHS		DAYS		HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
MARYLAND	U.S.A.			BALTIMORE COUNTY MD.					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
FORT HOWARD	VAMC, FORT HOWARD, MARYLAND			TRUCK HELPER					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE		
MARYLAND				BALTIMORE	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		603 PITCHER STREET 21217		
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
RUSSELL STEWART		ANNA STEWART							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
YES		WW II		CLIN. RECDS. VAMC, FT. HOWARD, MARYLAND					
220 12 6535									
18. CAUSE OF DEATH (Enter only one cause per line for 10a, 10b, and 10c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) RESPIRATORY FAILURE 2° PNEUMONIA									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b) ORGANIC BRAIN DISEASE									
DUE TO, OR AS A CONSEQUENCE OF									
(c) ALCOHOLIC LIVER DISEASE									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
		HOUR A.M. MONTH DAY YEAR							
		P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION					
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				CITY OR TOWN COUNTY STATE					
22a. I certify that (this hospital) attended the deceased from 8/8, 19 85, to 8/10, 19 85, that (we) lost saw the deceased alive on 8/10, 19 85, and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death.									
22b. SIGNATURE				DEGREE				22c. DATE SIGNED	
<i>George J. Vellnikaran</i>				MD				8/10/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS					
GEORGE J. VELLNIKARAN, M.D.				VA MEDICAL CENTER, FT. HOWARD, MD. 21052					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		STATE	
Burial		8-14-85		Garrison Forest Cemetery Owings Mills		Maryland			
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Bailey-Douglass Funeral Home 1348 N. Calhoun St.				AUG 14 1985		<i>John Davidson-Randall</i>			

MEDICAL CERTIFICATION

229

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the death certificate must be notified to the coroner.

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FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

21825

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) WILLIAM KEITH STIEBEL			2a. DATE KNOWN OF DEATH ESTIMATED AUGUST 25 1985			2b. HOUR 3A		
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 3 10 1962	6. AGE (IN YEARS) LAST BIRTHDAY 23 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD AUGUST 25 1985		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY		
10. CITY OR TOWN OF DEATH TIMONIUM		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GBMC 6701 N. CHARLES ST.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Student/Mercantile		12b. KIND OF BUSINESS OR INDUSTRY same
13a. STATE Md.			13b. COUNTY Baltimore	13c. CITY OR TOWN Timonium	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 8 Hammen Avenue, Timonium		
14. FATHER'S NAME FIRST MIDDLE LAST Alvin Frederick Stiebel				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Janet Helen Kuntzman				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 220-880-469		17. INFORMANT ADDRESS Mr. Alvin F. Stiebel, 8 Hammen Ave. 21093			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cordes Resisting Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Crushing Injury of Chest DUE TO, OR AS A CONSEQUENCE OF (c) probably Rupturing Aorta								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden Sudden
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 2 PM AUG 25 1985		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) On Passenger Seat of Auto Struck on the Side			
21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) 8 Street		21f. LOCATION STREET CITY OR TOWN COUNTY STATE York Rd & Belknap STAVE Timonium Baltimore			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE Charles O'Donnell			TITLE (SPECIFY) Deputy			DATE SIGNED 8/25/85		
EXAMINER'S NAME (TYPE OR PRINT) CHARLES O'DONNELL, M.D.			ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) Burial			23b. DATE 8/28/85			23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Cem.		
23d. LOCATION CITY OR TOWN Timonium			COUNTY Balto.			STATE Md.		
24. FUNERAL DIRECTOR NAME Lemmon-Mitchell-Wiedefeld			ADDRESS 10 W. Padonia Rd.			25a. DATE REC'D. BY REGISTRY AUG 27 1985		
25b. REGISTRY John Wiedefeld								

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1, 2, AND 3 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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FOR:
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mary Helen Stoecker			2a. DATE OF DEATH MONTH DAY YEAR 8 28 85		2b. HOUR M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 10 31 01		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.		
10. CITY OR TOWN OF DEATH Towson	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Manor Care Nursing Home-RUXTON		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Real Estate Ag.	12b. KIND OF BUSINESS OR INDUSTRY Back & Middle	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Baltimore 13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE River Real Estate 417 Riverside Dr. Essex 21221		
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Major			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-09-3879	17. INFORMANT ADDRESS Mrs. Ada J. Reese 227 Division Ave. 21093			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute CxH</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Alzheimer's Disease Arteriosclerosis</u>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Dr. Patricio</u>		DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Patricio		22e. ADDRESS 254-0392		2926 E. Cold Spring Lane Balto., Md. 21214	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 8-31-85	23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley M.G.	23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.		
24. FUNERAL DIRECTOR NAME Lassahn Funeral Home		25a. DATE REC'D. BY REGISTRAR BALTO, Md. 21226 SEP 03 1985	25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall		

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

810578

235158

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

21827

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Eva Straw			2a. DATE OF DEATH MONTH DAY YEAR August 16, 1985			2b. HOUR M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 21, 1893		6. AGE (IN YEARS LAST BIRTHDAY) 92 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD			
10. CITY OR TOWN OF DEATH Eastpoint		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7920 Bank Street				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Md.		13b. COUNTY Balto.		13c. CITY OR TOWN Eastpoint		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 7920 Bank St. 21224	
14. FATHER'S NAME FIRST MIDDLE LAST John Dietrick					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Doney				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 205074930		17. INFORMANT ADDRESS Nancy Kosmichy 7920 Bank St. 21224					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure due to severe E. Ascaris</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>E. Ascaris</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>E. Ascaris</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (the hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.)									
22a. SIGNATURE <i>T. A. Connelly</i>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) T. A. Connelly						22e. ADDRESS 2236 B. Blvd BALTO MD 21221			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8/20/1985		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith		23d. LOCATION CITY OR TOWN COUNTY STATE Rossville Balto. Md.		
24. FUNERAL DIRECTOR NAME ADDRESS Connelly Funeral Home 300 Mace Ave. 21221						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE AUG 21 1985	

MEDICAL CERTIFICATION

REBBI MOTTO & CO.

INDIAN WAREHOUSE



252035

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 1 8 2 8

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Eva M. SUEHS			2a. DATE OF DEATH MONTH DAY YEAR August 29, 1985		2b. HOUR 6:30A	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 6, 1999		
6. AGE (IN YEARS LAST BIRTHDAY) 86		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.				
10. CITY OR TOWN OF DEATH Rossville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT INSURE FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		
12b. KIND OF BUSINESS OR INDUSTRY						
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 13b. COUNTY Balto. 13c. CITY OR TOWN Middle River						
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 7323 Gunpowder Rd. 21220				
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Stenger			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217141670		17. INFORMANT ADDRESS Margaret Surguy 7323 Gunpowder Rd. 20		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Spontaneous Hemorrhage DUE TO, OR AS A CONSEQUENCE OF (b) Pancytopenia DUE TO, OR AS A CONSEQUENCE OF (c) Leukemia					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from July 31, 1985, to August 29, 1985, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on August 29, 1985, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.						
22b. SIGNATURE James Sides		DEGREE MD		22c. DATE SIGNED 8/29/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. Sides, M.D.		22e. ADDRESS 9000 Franklin Square Drive, 21237				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/31/85		23c. NAME OF CEMETERY OR CREMATORY Belair Cemetery		
23d. LOCATION (CITY OR TOWN) Calverton		23e. COUNTY Harford		23f. STATE Md.		
24. FUNERAL DIRECTOR Connolly Funeral Home 300 Race Ave. 21221			25a. DATE REC'D. BY REGISTRAR 'SEP 5 1985		25b. REGISTRAR'S SIGNATURE Davidson	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please return carbon papers. Pages 1 and 2 should be filled with the death information with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 1B, shows any injury, or other traumatic event, the medical examiner must be notified at

BP

100% COTTON

MADE IN U.S.A.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 21829

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST VICTOR W. SUSTA			2a. DATE OF DEATH MONTH DAY YEAR AUGUST 26, 1985		2b. HOUR 12:15 PM
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR JUNE 3, 1919		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS 66 6 38	7. UNDER 1 YEAR IF UNDER 24 HRS 6 38 85
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penn.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.	
10. CITY OR TOWN OF DEATH Towson	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. JOSEPH HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY BALTO. G. & E.
13a. STATE MARYLAND			13b. COUNTY BALTIMORE	13c. CITY OR TOWN PARKVILLE	
14. FATHER'S NAME FIRST MIDDLE LAST VINCENT SUSTA			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JOSEPHINE BUDREVICIUS		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W-W-II 166144044		17. INFORMANT ADDRESS FAMILY RECORDS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEVERE HYPOXIA. DUE TO, OR AS A CONSEQUENCE OF (b) VENTRICULAR ARRHYTHMIA CARDIAC ARREST. DUE TO, OR AS A CONSEQUENCE OF (c) PAST OF FISTULOUS ABCESS PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: PAST OP CA STOMACH. ASCVD. COPD.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 6 , 19 77 , to 5-27 , 19 85 , that (I) (we) lost saw the deceased alive on 5-26 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
22b. SIGNATURE Ruben S. Sebastian		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED AUG. 29, 1985	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. RUBEN S. SEBASTIAN		22e. ADDRESS 2314 EAST JOPPA ROAD - PARKVILLE			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE AUG. 30, 1985	23c. NAME OF CEMETERY OR CREMATORY GARDENS OF FAITH	23d. LOCATION CITY OR TOWN COUNTY STATE ROSEDALE BALTO. MARYLAND		
24. FUNERAL DIRECTOR NAME ADDRESS EVANS CHAPLOF MEMORIAL HARBOR RD. 8800		25a. DATE REC'D. BY REGISTRAR SEP 3 1985		25b. REGISTRAR'S SIGNATURE John Davidson-Randall	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

NOTES

10

NOTICE

240095

FOR
1. STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

21830

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
Mabel		G.		Swigart	8		16	85			M
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		
Female	White		8 21 07		77		MONTHS DAYS		HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						
Mena, Arkansas	USA				Baltimore County MD.						
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY						
Balto., County	5179 Terrace Drive 21236		Housewife		Homemaking						
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE						
Maryland	Baltimore	184-36-6802	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		5179 Terrace Drive 21236						
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			ADDRESS					
FIRST MIDDLE LAST Francis Cable Kirkpatrick			FIRST MIDDLE LAST Lula Smith								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT ADDRESS					
			184-36-6802			Jerry M. Swigart 5179 Terrace Dr. 21236					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hodgkins Disease</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on <u>7/10/85</u> , 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>MARVIN J. FELDMAN</u> 22b. PHYSICIAN'S NAME (TYPE OR PRINT)						DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED		
302 Green Spring Station Lutherville, Md.						22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE				
Burial			8-21-85		Hillsdale Cemetery		Middletown, Pennsylvania				
24. FUNERAL DIRECTOR NAME						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Lassahn Funeral Home						4401 Belair Rd. BALTO. MD. 21236		AUG 22 1985			

LINDAS

242094

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with your other death certificates with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 1B, shows any injury, or other traumatic event, the medical examiner must be notified immediately.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR		REG. NO.								
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH			2b. HOUR		
Marry Swindells					August 23, 1985			2:20 a.m.		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		
Female		White		Oct. 30, 1910		74 YRS.		MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
England		U.S.A.				Baltimore County MD.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Rossville 21237		Franklin Square Hospital				Sales Clerk		Store		
13a. STATE					13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Maryland					Baltimore		Middle River		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME					
John E. Wharmby					Frances Taylor					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No					219.30 8152		Dennis Swindells same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest; Bilateral Pneumonitis</u>										
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Leukemia</u>										
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Upper Gastrointestinal Bleeding</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)						
		HOUR A.M. MONTH DAY YEAR								
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION						
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET		CITY OR TOWN COUNTY STATE				
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>August 8</u> , 19 <u>85</u> , to <u>August 23</u> , 19 <u>85</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>August 23</u> , 19 <u>85</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (do not) view the body after death.										
22b. SIGNATURE						22c. DATE SIGNED				
<u>Thomas Lampone</u>						8/23/85				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS				
Thomas Lampone, M.D.						9000 Franklin Square Drive 21237				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION				
Cremation		8/24/85		Greenmount Cemetery		Baltimore City Maryland				
24. FUNERAL DIRECTOR						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
<u>James Brudzinski</u>						AUG 23 1985		<u>John Davidson</u>		
Brudzinski Funeral Home PA 1407 Old Eastern Ave.										

100510

• V. arrested 20 Feb. at age 1.6 years; identified

10/24/52 10/24/52 10/24/52 10/24/52 10/24/52

revised edition

238134

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

21832

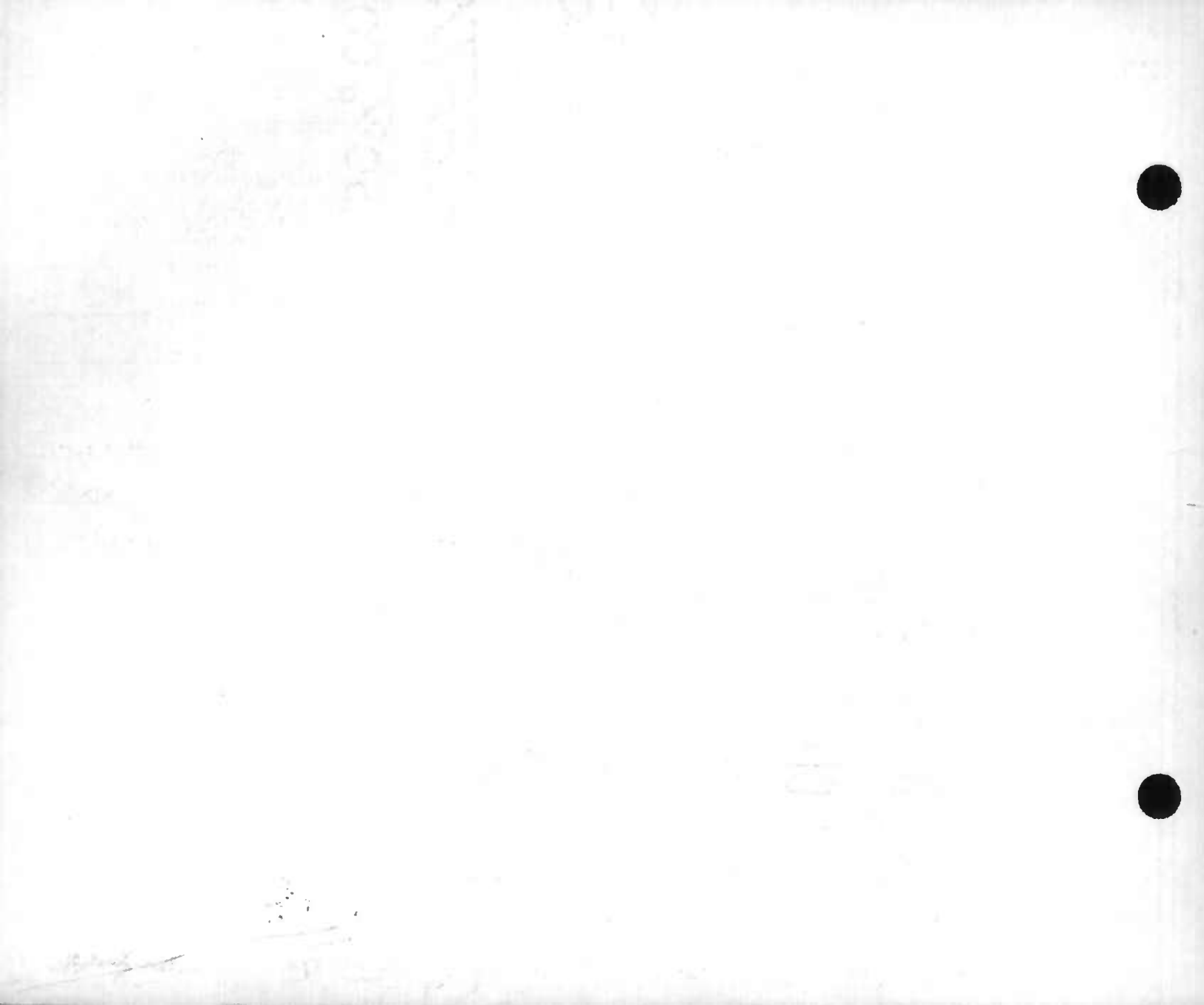
1. DECEASED NAME (TYPE OR PRINT) John Sykes			2a. DATE OF DEATH MONTH DAY YEAR 8 18 85			2b. HOUR M	
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 7 25 04		6. AGE (IN YEARS (LAST BIRTHDAY)) 81 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City Co. MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN BALTIMORE CITY, GIVE STREET ADDRESS) 5405 Montbell Ave.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
12b. KIND OF BUSINESS OR INDUSTRY							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE Md		13b. COUNTY Balt		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE 5405 Montbell Ave. 21207							
14. FATHER'S NAME FIRST MIDDLE LAST John sykes				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Emma Devone			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT ADDRESS Alice Medlin 1701 W. Lafayette Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Aspiration pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Bronchogenic carcinoma</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>16 minutes</u> <u>2 days</u> <u>8 months</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>None</u>							
19a. DATE OF OPERATION <u>None</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>July 20</u> 19 <u>85</u> , to <u>July 26</u> 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>July 26</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Ephraim Fuels, M.D.</u>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>					22c. DATE SIGNED <u>8/19/85</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Ephraim Fuels, M.D.</u>				22e. ADDRESS <u>600 N. Wolfe St. Baltimore, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/22/85		23c. NAME OF CEMETERY OR CREMATORY Holly Hill Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE White Marsh MD	
24. FUNERAL DIRECTOR NAME Wm C March F/H				ADDRESS 1101 E. North Ave		25a. DATE REC'D. BY REGISTRAR AUG 22 1985	
				25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the condition papers, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



220008

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

21833

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
FIRST MIDDLE LAST WALTER D TALBERT SR			MONTH DAY YEAR 08-05-85			M		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
MALE	CAUCASIAN	MONTH DAY YEAR 07 14 10	75 YRS			MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			
OVINGS MILLS	USA				BALTIMORE COUNTY MD			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
TOWSON	ST JOSEPH HOSPITAL			RETIRED WD. MD. RAILROAD				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)								
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE				
MD	BALTO	BALTIMORE	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	8710 EMGE ROAD 31234				
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
CHARLES A. TALBERT			ROSA V. HANSON					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS		
No			219-20-2562			MR. WALTER D. TALBERT JR. GLYNDON, MD.		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Acute Cerebrovascular accident

DUE TO, OR AS A CONSEQUENCE OF

(b) Diabetes mellitus Type I

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost

DUE TO, OR AS A CONSEQUENCE OF

(c) Hypertensive arteriosclerosis Cerebrovascular Disease

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I; OR PART 2)	
21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (1) this hospital attended the deceased from <u>May 8, 1985</u> to <u>August 5, 1985</u> that (2) we last saw the deceased alive on <u>8/1</u> 19 <u>85</u> and that (3) our opinion death occurred on the date and how and from the causes stated above (1) (a) (b) (c) (did not view the body after death)			
23a. SIGNATURE <u>Barry Joseph</u>		23b. DATE SIGNED 8/5/85	
23c. PHYSICIAN'S NAME (TYPE OR PRINT) BARRY JOSEPH		23d. ADDRESS 7600 OSLER A TOWSON MD	

24. BURIAL, CREMATION, REMOVAL (SPECIFY)	25a. DATE	25b. NAME OF CEMETERY OR CREMATORY	25c. LOCATION CITY OR TOWN COUNTY STATE
BURIAL	AUG. 8, 85	EVERGREEN MEMORIAL	FINKSBURG, MD.
26. FUNERAL DIRECTOR NAME ADDRESS		27a. DATED BY REGISTRAR 27b. REGISTRAR'S SIGNATURE	
ELINE FUNERAL HOME REISTERSTOWN, MD.		AUG 6 1985 J. Davidson-Randall	

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by a physician.

250008



CHINGS HILLS

USA

RETIRED WD. MD. RAILROAD

CHARLES A. TALBERT ROSA V. HANSON

NO 219-20-2525 MR. WALTER D. TALBERT JR. GLYNDON, MD.

BURIAL AUG. 8, 82 EVERGREEN MEMORIAL FINKSBURG, MD.

ELINE FUNERAL HOME REISTERSTOWN, MD.

220014

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

2 1 3 3 4

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Ethel E. Tarbutton			2a. DATE OF DEATH MONTH DAY YEAR August 1 1985		2b. HOUR 5:00am
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR November 8 1894		6. AGE (IN YEARS LAST BIRTHDAY) 90	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Randallstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Meridian Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Home Maker		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Baltimore	13c. CITY OR TOWN Woodlawn	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Alfred C. Jones			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ella L. Livingston		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-03-2853		17. INFORMATION ADDRESS Mrs. Doris A. Tarbutton 2613 Royal Oak Ave. Woodlawn Maryland	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u><i>Coronary Heart Failure</i></u> DUE TO, OR AS A CONSEQUENCE OF (b) <u><i>Arteriosclerotic Cardiovascular Disease</i></u> DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on <u><i>7/30</i></u> , 19 <u><i>85</i></u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <i>[Signature]</i>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 8/11/85
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Jerome Ginsberg		22e. ADDRESS 8630 LIBERTY PLAZA MALL RANDALLSTOWN, MARYLAND 21133	

MEDICAL CERTIFICATION

23a. BURIAL, CREMATION, REMOVAL Burial	23b. DATE 8/5/85	23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery	23d. LOCATION Woodlawn Baltimore Maryland
24. FUNERAL DIRECTOR Loring Byers Funeral Directors 8728 Liberty Road Randallstown, MD 21133-4784		25a. DATE REC'D. BY REGISTRAR AUG 6 1985	25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>

BP

TO HOSPITAL OR ATTENDING PHYSICIAN. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FL005



246050

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

21835

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Gladys K. K. Tatnall			2a. DATE OF DEATH MONTH DAY YEAR 8 24-85		2b. HOUR 1145 P.M.			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 2 16, 1895		6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.		
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dulaney Towson Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		
13a. STATE Maryland				13b. COUNTY Baltimore		13c. CITY OR TOWN Lutherville		
14. FATHER'S NAME FIRST MIDDLE LAST Andrew Heinz				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Uhlenberg				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 213-10-6975		17. INFORMANT ADDRESS Grace H. Mayes - Same as #13c				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure DUE TO, OR AS A CONSEQUENCE OF (b) arteriosclerotic vascular disease DUE TO, OR AS A CONSEQUENCE OF (c) fracture Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) Diabetes Mellitus								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 2 April 85 to 24 August 85 , that (I) (we) lost saw the deceased alive on 24 August 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Walter T. Kees				DEGREE MD		22c. DATE SIGNED 25 August 1985		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Walter T. Kees				22e. ADDRESS Monkton Md 21111				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-27-85		23c. NAME OF CEMETERY OR CREMATORY Lorraine Park		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.		
24. FUNERAL DIRECTOR NAME ADDRESS Ruck Towson Funeral Home, Inc. Towson, Md. 21204				25a. DATE REC'D. BY REGISTRAR AUG 28 1985		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and file with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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233113

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

21836

1 DECEASED NAME (TYPE OR PRINT) Mildred L. TAWNEY			2a DATE OF DEATH MONTH DAY YEAR August 14, 1985		2b HOUR 10:05P_M
3 SEX FEMALE	4 RACE CAUCASIAN	5 DATE OF BIRTH MONTH DAY YEAR 03 09 20		6 AGE (IN YEARS LAST BIRTHDAY) 65 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) WEST VIRGINIA	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10 CITY OR TOWN OF DEATH ROSSVILLE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION FRANKLIN SQUARE HOSPITAL		12a USUAL OCCUPATION (TYPE OR PRINT) (GIVE IF WORKING LIFE) HOUSEWIFE	12b KIND OF BUSINESS OR INDUSTRY -----	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE MARYLAND	13b. COUNTY BALTIMORE, BALTIMORE	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 1202 N. 63rd St. 21237	
14. FATHER'S NAME FIRST MIDDLE LAST CLINTON MONTGOMERY		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MAUDE ROSE SAMS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 234058753		17 INFORMANT ADDRESS ROBERT TAWNEY 1202 N. 63RD ST.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Lung Cancer DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from August 5 19 85 , to August 14 19 85 , that <input checked="" type="checkbox"/> (we) lost the deceased alive on August 14 19 85 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (we) did <input type="checkbox"/> (we) did not view the body after death.					
22b. SIGNATURE Luisa F. Massari MD. DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 8/14/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Luisa F. Massari, MD			22e. ADDRESS 9000 Franklin Square Dr., 21237		
23a. BURIAL, CREMATION, REMOVAL (CHECK ONE) BURIAL		23b. DATE 8/17/85	23c. NAME OF CEMETERY OR CREMATORY GARDENS OF FAITH		23d. LOCATION CITY OR TOWN COUNTY STATE BAITO. BALTO. MD.
24. FUNERAL DIRECTOR J. J. [Signature] ADDRESS 1211 Chesa Ave			25a. DATE REC'D. BY REGISTRAR AUG 16 1985 25b. REGISTRAR'S SIGNATURE [Signature]		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be filed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and community health nurse, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

RECEIVED
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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

21837

1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
William M. TEPPIG Sr.		August 27, 1985		1:46a M	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
MALE	CAUCASIAN	2-27-1920	65 yrs.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Indiana	USA		Baltimore County MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Baltimore	Franklin Square Hospital		Manager		Spirit World
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE	
Md.	Balto.	Balto.		21222 7855 Rockbourne Road	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
Conrad W. Teppig		Ruth F. Gregg			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
yes		WWII 317-03-7125		Alberta Teppig same address #13e	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage, Lung Carcinoma with Esophageal Erosion					
DUE TO, OR AS A CONSEQUENCE OF (b)					
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that X (this hospital) attended the deceased from August 22, 19 85, to August 27, 19 85, that X (we) last saw the deceased alive on August 27, 19 85, and that in X (our) opinion death occurred on the date and hour and from the causes stated above, X (we) (did) (not) view the body after death.					
22b. SIGNATURE Grim		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 8-26-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A.H. Grim M.D.		22e. ADDRESS 9000 Franklin Square Dr., 21237			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		8-30-85		Meadowridge Mem. Park, Balto. Md,	
23d. LOCATION CITY OR TOWN COUNTY STATE		23e. DATE REC'D. BY REGISTRAR			
		AUG 27 1985			
24. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane, Balto., Md. 21213		25b. REGISTRAR'S SIGNATURE Lisa Davidson-Randall			

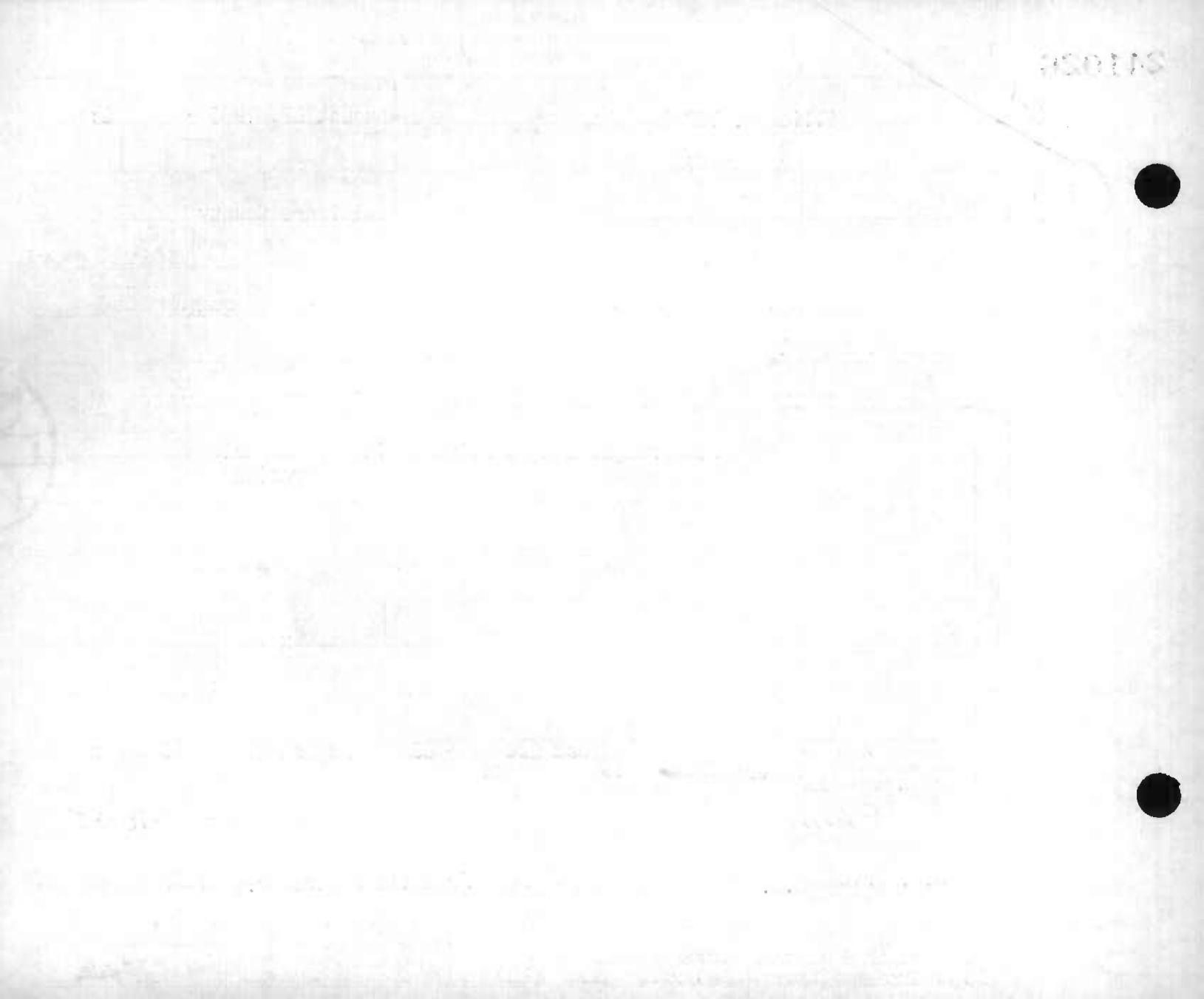
MEDICAL CERTIFICATION

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be buried with the deceased 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 states any injury, or other traumatic event, the medical examiner must be notified.



218070

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

21838

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) HERMAN CHARLES THIELE, SR.			2a. DATE OF DEATH MONTH DAY YEAR 8 30 85			2b. HOUR 8:00P M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 2 17 25		6. AGE (IN YEARS LAST BIRTHDAY) 60		7. IF UNDER 1 YEAR MONTHS DAYS 0 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH Lansdowne		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 204 Minebank Lane				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Drive		12b. KIND OF BUSINESS OR INDUSTRY Colonial Excavating Co.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Lansdowne		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 204 Minebank Lane 21227	
14. FATHER'S NAME FIRST MIDDLE LAST Adolfus Thiele				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Heinzerling					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII 218-18-0628		17. INFORMANT ADDRESS Margaret Noreen Thiele 204 Minebank Ln. 21227			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Squamous cell carcinoma Floor DUE TO, OR AS A CONSEQUENCE OF (b) OF MOUTH Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) ADENOCARCINOMA OF RECTUM									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN IDENTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Anthony F. Hammond				DEGREE MD				22c. DATE SIGNED Aug 31 1985	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Anthony Hammond				22e. ADDRESS Pine Hgts. Med Center					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/3/85		23c. NAME OF CEMETERY OR CREMATORY Meadowridge mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Elkridge Howard Maryland			
24. FUNERAL DIRECTOR NAME ADDRESS Hubbard Funeral Home, Inc. 4107 Wilkens Ave. 21229				25a. DATE REC'D. BY REGISTRAR SEP 3 1985		25b. REGISTRAR'S SIGNATURE [Signature]			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the funeral director must be notified immediately.

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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

2181369

1. DECEASED NAME (TYPE OR PRINT) Hortense O Tillman			2a. DATE OF DEATH MONTH DAY YEAR 8-15-85			2b. HOUR 12:55 A			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 9 29 1898		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore Co. MD.			
10. CITY OR TOWN OF DEATH Rockyville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland Masonic Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Domestic	
13a. STATE Maryland			13b. COUNTY Anne Arundell		13c. CITY OR TOWN Linthicum		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Henry August Dahle			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eva L Gast			16. STREET ADDRESS / ZIP CODE 6422 St. Phillips Rd. 21090			
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			18. SOCIAL SECURITY NO. 214-50-7602		19. INFORMANT ADDRESS Herman Tillman Same as #13				
20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sepsis DUE TO, OR AS A CONSEQUENCE OF (b) Infection of left leg DUE TO, OR AS A CONSEQUENCE OF (c) Embolism PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
21a. DATE OF OPERATION			21b. CONDITION FOR WHICH OPERATION WAS PERFORMED			21c. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		21d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
22a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			22b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			22c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
23a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			23b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			23c. LOCATION STREET CITY OR TOWN COUNTY STATE			
24. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
25. SIGNATURE Paul Rivas DEGREE						26. DATE SIGNED 8-16-85		27. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
28. PHYSICIAN'S NAME (TYPE OR PRINT) Paul Rivas						29. ADDRESS Maryland Masonic Homes			
30. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			31. DATE 8-17-85		32. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery Brooklyn A.A.		33. LOCATION CITY OR TOWN COUNTY STATE Balto. Md. 21225		
34. FUNERAL DIRECTOR McCully Funeral Home						35. DATE REC'D. BY REGISTRAR AUG 19 1985			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove captioned papers, Pages 1 and 2, and send them to the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

SALES

7

Handwritten notes and signatures at the top of the page, including a signature that appears to be "John" and some illegible text.

Main body of handwritten text, appearing to be a letter or report, with several lines of cursive script.

Large handwritten signature or initials in the bottom right corner, possibly "J. B. Smith" or similar.

249015

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

21340

1 - FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOHN C. TILLMAN			2a. DATE OF DEATH MONTH DAY YEAR AUGUST 29 1985		2b. HOUR 8:07 AM	
3. SEX Male		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JUNE 6 1907		
6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		8. CITIZEN OF WHAT COUNTRY? USA		
9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. CITY OR TOWN OF DEATH TOWSON		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PAYROLL CLERK		12b. KIND OF BUSINESS OR INDUSTRY BETH. STEEL		13a. STATE MD.		
13b. CITY OR TOWN BALTIMORE		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE 3238 CLIFTMONT AVE. 21213		
14. FATHER'S NAME FIRST MIDDLE LAST JOHN TILLMAN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ALICE PHILLIPS		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		
16b. SOCIAL SECURITY NO. 213-09-2800		17. INFORMANT ADDRESS CATHERINE TILLMAN (WIFE) SAME ADDRESS		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO-PULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) ANTERIO SCLEROTIC CARDIOVASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) POST-OPERATIVE REPAIR OF INCARCERATED LEFT SCROTAL HERNIA		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: POST-OPERATIVE REPAIR OF INCARCERATED LEFT SCROTAL HERNIA						
19a. DATE OF OPERATION 8/27/85		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED INCARCERATED LEFT SCROTAL HERNIA		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.) 4-1		21f. LOCATION CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 7-31 , 19 85 , to 8-29 , 19 85 , that (I) (we) last saw the deceased alive on 8-28 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE A. Andrew Accce, M.D.		DEGREE M.D.		22c. DATE SIGNED 8/29/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. ANDREW ACCCE, M.D.		22e. ADDRESS 7401 ASKER DRIVE - TOWSON, MD 21204				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 9/3/85		23c. NAME OF CEMETERY OR CREMATORY HOLY REDEEMER		
23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD.		24. FUNERAL DIRECTOR NAME ADDRESS SCHIMUNEK FUNERAL HOME INC. 3331 Brehms Lane, Balto. Md. 21213				
25a. DATE RECEIVED BY REGISTRAR SEP 3 1985		25b. REGISTRAR'S SIGNATURE [Signature]				

MEDICAL CERTIFICATION

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical certificate must be notified on page 1.

241122

 1- FOR STATE REGISTRAR
 XC 4995489

 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

REG. NO.

21841

1. DECEASED NAME (TYPE OR PRINT) EPH TODD			2a. DATE OF DEATH MONTH DAY YEAR AUGUST 24, 1985			2b. HOUR 6:10 A.M.			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR FEBRUARY 29, 1920		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) TENNESSEE		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.			
10. CITY OR TOWN OF DEATH FORT HOWARD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) V.A. MEDICAL CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) GROUNDSMAN		12b. KIND OF BUSINESS OR INDUSTRY EDUCATION	
13a. STATE MARYLAND			13b. COUNTY BALTIMORE		13c. CITY OR TOWN Dundalk		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13e. STREET ADDRESS / ZIP CODE 8023 PARK HAVEN ROAD/21222			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST VINNEY HIGGINS						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES			16b. SOCIAL SECURITY NO. W.W. II 413 22 1767		17. INFORMANT ADDRESS CLINICAL RECORDS, VAMC, FORT HOWARD, MD				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY ARTERY DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 25 MINUTES YEARS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. HISTORY OF CARDIAC ARRHYTHMIA WITH ASCVD / BILATERAL CVA'S									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from MAY 23 , 19 84 , to AUGUST 24 , 19 85 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on AUGUST 24 , 19 85 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (not) view the body after death.									
22b. SIGNATURE <i>G. Hardy</i>						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 8/24/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GLENN HARDY, M.D.						22e. ADDRESS VAMC, FORT HOWARD, MD 21052			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8/27/1985		23c. NAME OF CEMETERY OR CREMATORY Meadowridge		23d. LOCATION CITY OR TOWN COUNTY STATE Dorsey Howard Maryland		
24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc. ADDRESS 7922 Wise Avenue Dundalk, MD. 21222						25a. DATE REC'D. BY REGISTRAR AUG 27 1985		25b. REGISTRAR'S SIGNATURE <i>John Davidson</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be held until 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified to examine the body.

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 221. 222. 223. 224. 225. 226. 227. 228. 229. 230. 231. 232. 233. 234. 235. 236. 237. 238. 239. 240. 241. 242. 243. 244. 245. 246. 247. 248. 249. 250. 251. 252. 253. 254. 255. 256. 257. 258. 259. 260. 261. 262. 263. 264. 265. 266. 267. 268. 269. 270. 271. 272. 273. 274. 275. 276. 277. 278. 279. 280. 281. 282. 283. 284. 285. 286. 287. 288. 289. 290. 291. 292. 293. 294. 295. 296. 297. 298. 299. 300. 301. 302. 303. 304. 305. 306. 307. 308. 309. 310. 311. 312. 313. 314. 315. 316. 317. 318. 319. 320. 321. 322. 323. 324. 325. 326. 327. 328. 329. 330. 331. 332. 333. 334. 335. 336. 337. 338. 339. 340. 341. 342. 343. 344. 345. 346. 347. 348. 349. 350. 351. 352. 353. 354. 355. 356. 357. 358. 359. 360. 361. 362. 363. 364. 365. 366. 367. 368. 369. 370. 371. 372. 373. 374. 375. 376. 377. 378. 379. 380. 381. 382. 383. 384. 385. 386. 387. 388. 389. 390. 391. 392. 393. 394. 395. 396. 397. 398. 399. 400. 401. 402. 403. 404. 405. 406. 407. 408. 409. 410. 411. 412. 413. 414. 415. 416. 417. 418. 419. 420. 421. 422. 423. 424. 425. 426. 427. 428. 429. 430. 431. 432. 433. 434. 435. 436. 437. 438. 439. 440. 441. 442. 443. 444. 445. 446. 447. 448. 449. 450. 451. 452. 453. 454. 455. 456. 457. 458. 459. 460. 461. 462. 463. 464. 465. 466. 467. 468. 469. 470. 471. 472. 473. 474. 475. 476. 477. 478. 479. 480. 481. 482. 483. 484. 485. 486. 487. 488. 489. 490. 491. 492. 493. 494. 495. 496. 497. 498. 499. 500. 501. 502. 503. 504. 505. 506. 507. 508. 509. 510. 511. 512. 513. 514. 515. 516. 517. 518. 519. 520. 521. 522. 523. 524. 525. 526. 527. 528. 529. 530. 531. 532. 533. 534. 535. 536. 537. 538. 539. 540. 541. 542. 543. 544. 545. 546. 547. 548. 549. 550. 551. 552. 553. 554. 555. 556. 557. 558. 559. 560. 561. 562. 563. 564. 565. 566. 567. 568. 569. 570. 571. 572. 573. 574. 575. 576. 577. 578. 579. 580. 581. 582. 583. 584. 585. 586. 587. 588. 589. 590. 591. 592. 593. 594. 595. 596. 597. 598. 599. 600. 601. 602. 603. 604. 605. 606. 607. 608. 609. 610. 611. 612. 613. 614. 615. 616. 617. 618. 619. 620. 621. 622. 623. 624. 625. 626. 627. 628. 629. 630. 631. 632. 633. 634. 635. 636. 637. 638. 639. 640. 641. 642. 643. 644. 645. 646. 647. 648. 649. 650. 651. 652. 653. 654. 655. 656. 657. 658. 659. 660. 661. 662. 663. 664. 665. 666. 667. 668. 669. 670. 671. 672. 673. 674. 675. 676. 677. 678. 679. 680. 681. 682. 683. 684. 685. 686. 687. 688. 689. 690. 691. 692. 693. 694. 695. 696. 697. 698. 699. 700. 701. 702. 703. 704. 705. 706. 707. 708. 709. 710. 711. 712. 713. 714. 715. 716. 717. 718. 719. 720. 721. 722. 723. 724. 725. 726. 727. 728. 729. 730. 731. 732. 733. 734. 735. 736. 737. 738. 739. 740. 741. 742. 743. 744. 745. 746. 747. 748. 749. 750. 751. 752. 753. 754. 755. 756. 757. 758. 759. 760. 761. 762. 763. 764. 765. 766. 767. 768. 769. 770. 771. 772. 773. 774. 775. 776. 777. 778. 779. 780. 781. 782. 783. 784. 785. 786. 787. 788. 789. 790. 791. 792. 793. 794. 795. 796. 797. 798. 799. 800. 801. 802. 803. 804. 805. 806. 807. 808. 809. 810. 811. 812. 813. 814. 815. 816. 817. 818. 819. 820. 821. 822. 823. 824. 825. 826. 827. 828. 829. 830. 831. 832. 833. 834. 835. 836. 837. 838. 839. 840. 84

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

21842

228013

1 -
FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | |
|---|--|---|---|---|--------------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST: Noel, MIDDLE: Oden, LAST: Towner | | | 2a. DATE OF DEATH
MONTH: August, DAY: 13, YEAR: 1985 | | 2b. HOUR
6:05 a.m. | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH: 7, DAY: 23, YEAR: 10 | | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
75 YRS. | | IF UNDER 1 YEAR
MONTHS: , DAYS: | | IF UNDER 24 HRS.
HOURS: , MIN: | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
West Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore County MD. | | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 10. CITY OR TOWN OF DEATH
Rossville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Franklin Square Hospital | | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | | 12b. KIND OF BUSINESS OR INDUSTRY
Martin-Marietta | | | | |
| 13a. STATE
Maryland | | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Eastpoint | |
| 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET ADDRESS & ZIP CODE
7814 Eastdale Road 21224 | | | |
| 14. FATHER'S NAME
FIRST: James, MIDDLE: Oden, LAST: Towner | | | 15. MOTHER'S MAIDEN NAME
FIRST: Sally, MIDDLE: Virginia, LAST: Price | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
234-01-8525 | | 17. INFORMANT
ADDRESS
Betty M. Sherrard P.O. Box 26 Inwood W. Va. 25428 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiopulmonary Arrest
DUE TO, OR AS A CONSEQUENCE OF (b): Cerebral Vascular Accident
DUE TO, OR AS A CONSEQUENCE OF (c): Hypertension with Artherosclerotic Vascular Disease
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL ILLNESS OR CONDITION GIVEN IN PART 1 (a): Chronic Obstructive Pulmonary Disease | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | |
| 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from July 30 19 85 to August 13 19 85, that <input checked="" type="checkbox"/> (we) lost sight of the deceased alive on August 13 19 85, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. | | | | |
| 22b. SIGNATURE
Keith English, M.D. | | DEGREE
M.D. | | 22c. DATE SIGNED
8/13/85 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Keith English, M.D. | | 22e. ADDRESS
9000 Franklin Square Drive 21237 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
8-16-85 | | 23c. NAME OF CEMETERY OR CREMATORY
Oak Lawn Cemetery | | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Eastwood, Balts. Co., Md. | | 24. FUNERAL DIRECTOR
NAME Charles S. Zeiler & Son Inc. ADDRESS 6224 Eastern Ave. | | | | |
| 25a. DATE REC'D. BY REGISTRAR
AUG 14 1985 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper from page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be contacted and advised.

438013

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|------------------------|----|----|----|----|
| White | 1 | 23 | 10 | 75 |
| U.S.A. | xx | | | |
| Family Spinal Hospital | | | | |
| Rockville | | | | |
| Virginia | | | | |
| U.S.A. | | | | |
| White | | | | |
| 1 | | | | |
| 23 | | | | |
| 10 | | | | |
| 75 | | | | |

xx

Family Spinal Hospital

Rockville

Virginia

U.S.A.

White

1

23

10

75



U.S. National Archives and Records Administration

7-1-75

Rockville, Virginia

220077

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

21043
1. FOR STATE REGISTRAR
2a. DATE OF DEATH MONTH DAY YEAR 08 01 85
2b. HOUR 6:20P M

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ARTHUR TOWNSHEND JR.
3. SEX Male 4. RACE White 5. DATE OF BIRTH MONTH DAY YEAR April 24, 1904
6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland 7b. CITIZEN OF WHAT COUNTRY? USA
8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CO., MD.
10. CITY OR TOWN OF DEATH TOWSON 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) G.B.M.C. 6701 N. CHARLES STREET
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesman 12b. KIND OF BUSINESS OR INDUSTRY Life Co.
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland 13c. CITY OR TOWN Baltimore
14. FATHER'S NAME FIRST MIDDLE LAST Arthur Townshend, Sr. 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Susan Offutt
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No 16b. SOCIAL SECURITY NO. 159-07-7094 17. INFORMANT ADDRESS M. Evelyn Townshend Same

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) RESPIRATORY ARREST SECONDARY TO CHRONIC SEVERE C.O.P.D.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) DUE TO, OR AS A CONSEQUENCE OF
(c) DUE TO, OR AS A CONSEQUENCE OF

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

ATRIAL FIBRILLATION

19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 20a. AUTOPSY? YES ☐ NO ☐
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE ☐ AT WORK NOT WHILE ☐ AT WORK
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION STREET CITY OR TOWN COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from 07/26, 1985, to 08/01, 1985, that (I) (we) last saw the deceased alive on 08/01, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.
22b. SIGNATURE Michael A. Smith MD DEGREE 22c. DATE SIGNED 8/11/85
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. MICHAEL A. SMITH 22e. ADDRESS GREATER BALTIMORE MEDICAL CENTER

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 23b. DATE Aug. 5, 1985 23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park 23d. LOCATION CITY OR TOWN COUNTY STATE Parkville, Baltimore Co., Md.
24. FUNERAL DIRECTOR NAME ADDRESS 6500 York Rd. 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE Mitchell-Wiedefeld Home, Inc. Balto., Md. 21212 AUG 6 1985 [Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical investigation conducted.

MEDICAL CERTIFICATION

BP

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RECEIVED

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

21844

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | |
|--|--|--|--|---|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
James TUCCIARELLA | | | 2a. DATE OF DEATH
MONTH DAY YEAR
August 28, 1985 | | | 2b. HOUR
2:10a M | | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
5/20/1923 | | 6. AGE (IN YEARS LAST BIRTHDAY)
62 YRS | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore County MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Rossville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Franklin Square Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | | 12b. KIND OF BUSINESS OR INDUSTRY
Beth Steel | | |
| 13a. STATE
Maryland | | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Essex | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
321 Margaret Ave. 21221 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Vincenzo Tucciarella | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Carmella Gueniglia | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
yes | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WWII | | 17. INFORMANT
Gloria Tucciarella | | ADDRESS
321 Margaret Ave. 21 | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **Cardiac Arrest; Probable Myocardial Infarction**

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

Pulmonary Edema

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from August 27, 1985 to August 28, 1985 , that <input checked="" type="checkbox"/> (we) lost
saw the deceased alive on August 28, 1985 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated
above. (We) (did) (not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<i>Vincent Morgan</i> | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
8-28-85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Vincent Morgan, M.D. | | | | 22e. ADDRESS
9000 Franklin Square Dr., 21237 | | | |

| | | | | | | | |
|---|--|-----------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
burial | | 23b. DATE
8/30/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Highveiw Memorial | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Fallston Harford Md. | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Connelly Funeral Home 300 Ave. 21221 | | | | 25a. DATE REC'D. BY REGISTRAR
SEP 5 1985 | | 25b. REGISTRAR'S SIGNATURE
<i>W. Davidson-Ponder</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

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COLON 618-18

one only

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

21845

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) CHARLES J. TURNER | | | 2a. DATE OF DEATH MONTH DAY YEAR
AUGUST 29, 1985 | | | 2b. HOUR P.
P. | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
SEPT. 7, 1906 | | 6. AGE (IN YEARS LAST BIRTHDAY)
79 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH
Towson | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
ST. JOSEPH HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
CLERK | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a STATE MARYLAND 13b COUNTY BALTIMORE 13c CITY OR TOWN PARKVILLE | | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
3215 WOODSIDE AVZ. 21234 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
CHARLES S. TURNER | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ALICE BORCHARD | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
705 05 3021 | | 17. INFORMANT
ADDRESS
FAMILY RECORDS | | | |

| | | |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST
DUE TO, OR AS A CONSEQUENCE OF
(b) ATHEROSCLEROTIC CARDIOVASCULAR DISEASE YEARS
DUE TO, OR AS A CONSEQUENCE OF
(c) VALVULAR HEART DISEASE YRS | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
5 MIN |
|---|--|---|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

PARKINSONS DISEASE, PROSTATIC ENLARGEMENT

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from SEPT 5, 1984 to JULY 10, 1985 , that (I) (we) last saw the deceased alive on JULY 10, 1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Richard W. Bittick MD | | | | DEGREE
MD | | 22c. DATE SIGNED
SEPT 3 1985 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DR. RICHARD W. BITTRICK | | | | 22e. ADDRESS
8100 HARFORD ROAD - PARKVILLE | | | |

| | | | | | | | |
|--|--|------------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
9-3-1985 | | 23c. NAME OF CEMETERY OR CREMATORY
DUBANSY VALLEY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Timonium BALTO-MARYLAND | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
EVANS CHAPL OF MEMORIALS HARFORD RO. 8800 | | | | 25a. DATE REC'D. BY REGISTRAR
SEP 3 1985 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | |

1. The first part of the report is a general description of the project. It includes the title, the objectives, the scope, and the methodology. The title is "The Effect of Temperature on the Rate of Reaction of Hydrogen Peroxide with Potassium Iodide". The objectives are to determine the effect of temperature on the rate of reaction and to determine the activation energy of the reaction. The scope is limited to the reaction of hydrogen peroxide with potassium iodide in aqueous solution. The methodology involves measuring the rate of reaction at different temperatures and using the Arrhenius equation to determine the activation energy.

2. The second part of the report is a detailed description of the experimental procedure. It includes the list of materials and equipment, the safety precautions, and the step-by-step procedure for the experiment. The materials and equipment include hydrogen peroxide, potassium iodide, distilled water, a thermometer, a stopwatch, and a graduated cylinder. The safety precautions include wearing gloves and goggles, and avoiding contact with the chemicals. The procedure involves measuring a fixed volume of hydrogen peroxide and potassium iodide solutions, mixing them in a beaker, and measuring the time taken for a fixed volume of iodine to be produced. This is done at different temperatures, and the rate of reaction is calculated from the time taken.

3. The third part of the report is a discussion of the results. It includes a table of the data, a graph of the rate of reaction against temperature, and a calculation of the activation energy. The data shows that the rate of reaction increases with temperature. The graph is a straight line, and the activation energy is calculated from the slope of the line. The activation energy is found to be 50 kJ/mol.

4. The fourth part of the report is a conclusion. It summarizes the findings of the experiment and discusses the implications. The findings show that the rate of reaction increases with temperature, and the activation energy is 50 kJ/mol. The implications are that the reaction is exothermic, and the rate of reaction can be controlled by changing the temperature.

246087

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

21846

FOR
1. STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|---|--|---|---|---|-----------------------------------|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Harry Stanford Tyler | | | 2a. DATE OF DEATH
MONTH DAY YEAR
August 26, 1985 | | | 2b. HOUR
M | | | |
| 3 SEX
Male | | 4 RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
November 20, 1905 | | 6 AGE (IN YEARS LAST BIRTHDAY)
79 YRS | | IF UNDER 7 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore County, MD. | | | |
| 10 CITY OR TOWN OF DEATH
Cockeysville, | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
5 Summit Green Court | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Supervisor- | | 12b. KIND OF BUSINESS OR INDUSTRY
Engineering | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Cockeysville | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Capt. Edward Pierce Tyler | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Edna Bloxom | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | | |
| 16b. SOCIAL SECURITY NO.
1923-1927 | | | 17. INFORMANT
ADDRESS
Cockeysville, 21030 | | | 17. INFORMANT
Elizabeth B. Tyler, 5 Summit Green Court, | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

COPD

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL

BETWEEN ONSET AND DEATH

YEARS

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:

MEDICAL CERTIFICATION

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (his hospital) attended the deceased from <u>Oct 3</u> , 19 <u>73</u> , to <u>August 26</u> , 19 <u>85</u> , that (I) (we) last
saw the deceased alive on <u>August 26</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 27b. SIGNATURE
<u>McRae W. Williams</u> | | | | DEGREE
M.D. | | 27c. DATE SIGNED
8/29/85 | |
| 27d. PHYSICIAN'S NAME (TYPE OR PRINT)
McRae W. Williams, M.D. | | | | 27e. ADDRESS
201 E. University Pkwy, Balto., Md. 21218 | | | |

| | | | | | | | |
|---|--|----------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
8/29/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park Cemetery, Balto., City., Maryland | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | |
| 24. FUNERAL DIRECTOR
NAME
Martin D. Lawson, 10W. Padonia Road, Timonium | | | | 25a. DATE REC'D. BY REGISTRAR
AUG 29 1985 | | 25b. REGISTRAR'S SIGNATURE
<u>John Davidson-Randall</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

Handwritten notes and stamps, including a circular seal with a cross and the word "FEDERAL" visible. The text is mostly illegible due to fading and bleed-through.

228054

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3. RETURN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

| JAMES FRANK VACOVSKY III | | | STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | 21847 | | |
|---|--|--|---|---|---|---|--|--|
| FOR
1- STATE REGISTRAR | | | REG. NO. | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) JAMES FRANK VACOVSKY II | | | | | | 7a. DATE KNOWN OF DEATH 8/11 1985 | | |
| 3. SEX
MALE | | 4. RACE
CAUCAS. | | 5. DATE OF BIRTH
MONTH 02 DAY 24 YEAR 60 | | 6. AGE (IN YEARS)
LAST BIRTHDAY 25 YRS. | | 7b. DATE KNOWN OF DEATH 8/12 1985 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE COUNTY | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
MARTIN'S LAGOON | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
LABORER | | 12b. KIND OF BUSINESS OR INDUSTRY
PLASTICS |
| 13a. STATE
MARYLAND | | | 13b. CITY
BALTIMORE | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST JAMES MIDDLE FRANK LAST VACOVSKY JR. | | | 15. MOTHER'S MAIDEN NAME
FIRST HELEN MIDDLE CALO LAST CALO | | | 13e. STREET ADDRESS
30 BEECH DR. 21220 | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)
NO | | | 16b. SOCIAL SECURITY NO.
218729619 | | 17. INFORMANT
FRANK VACOVSKY ADDRESS
7921 ROSELAND AVE. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Drowning
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 8/40 1985 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
Drowning while swimming | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
Maxim Lagoon | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | |
| ACTUAL SIGNATURE
K.S. AHLUWALIA | | | TITLE (SPECIFY)
Deputy | | | DATE SIGNED
8/12/85 | | |
| EXAMINER'S NAME
(TYPE OR PRINT) | | | ADDRESS
2112 Dundalk Ave 410 21222 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
BURIAL | | | 23b. DATE
08/16/85 | | 23c. NAME OF CEMETERY OR CREMATORY
GARDENS OF FAITH | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTO. BALTO. MD. | |
| 24. FUNERAL DIRECTOR
NAME
J. L. L. L. | | | ADDRESS
211 Chesapeake Ave | | | 25a. DATE REC'D. BY REGISTRAR
AUG 13 1985 | | 25b. REGISTRAR'S SIGNATURE
John Davidson |

SS2001



234009

Film 608 item 6
FOR
STATE 10/22/85 rja
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

21848

REG. NO.

| | | | | | | | | | | |
|---|--|--|---|--|--|---|--|---|--|---|
| 1 DECEASED NAME
(TYPE OR PRINT)
THEODORE R. VANLEEUWEN | | | 2a DATE OF DEATH
MONTH DAY YEAR
AUGUST 17, 1985 | | | 2b HOUR
9:07 AM | | | | |
| 3 SEX
Male | | 4 RACE
White | | 5 DATE OF BIRTH
MONTH DAY YEAR
Jan. 20 1903 | | 6 AGE (IN YEARS LAST BIRTHDAY)
81 82 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b CITIZEN OF WHAT COUNTRY?
USA | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE COUNTY MD. | | | | |
| 10 CITY OR TOWN OF DEATH
TOWSON | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
ST. JOSEPH HOSPITAL | | | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Electrician | | 12b KIND OF BUSINESS OR INDUSTRY
Electrical | | |
| 13a STATE
Maryland | | | | | 13b CITY OR TOWN
Baltimore | | 13c STREET ADDRESS / ZIP CODE
1023 Cedarcroft Rd., 21212 | | | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
Theodore Joseph Vanleeuwen | | | | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ada Virginia Evans | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
- | | 17 INFORMANT
ADDRESS
Russell L. Brown, 218 Old Padonia Rd. | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) <u>Searciousness of the lung & hypercalcemia and</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>hypertension</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>MALIGNANT MESENTERIA</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>21030</u> | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19a DATE OF OPERATION | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
9:22 AM 8 17 1985 | | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f LOCATION
STREET CITY OR TOWN COUNTY STATE | | 21g | | |
| 22a I certify that (I) (this hospital) attended the deceased from <u>8/16</u> 19 <u>85</u> , to <u>8/17</u> 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>8/16</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b SIGNATURE
<u>Sam A. Graham</u> | | | | | DEGREE <u>MD</u>
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c DATE SIGNED
8-17-85 | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)
SAM A. GRAHAM | | | | | 22e ADDRESS
St. Joseph's Hospital | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b DATE
8/21/85 | | 23c NAME OF CEMETERY OR CREMATORY
Hampstead Cemetery | | 23d LOCATION
CITY OR TOWN COUNTY STATE
Hampstead Carroll Md. | | | |
| 24 FUNERAL DIRECTOR
Bryan W. Clary, 10 W. Padonia Rd. 21093 | | | | | 25a DATE REC'D. BY REGISTRAR
AUG 19 1985 | | | | | 25b REGISTRAR'S SIGNATURE
<u>John Davidson</u> |

MEDICAL CERTIFICATION

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene.
 IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

ENDS

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

21849

249101

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Viola Marie Volkert | | | 2a. DATE OF DEATH
MONTH DAY YEAR
8 29 85 | | | 2b. HOUR
5 40 P.M. | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
1 23 96 | | 6. AGE (IN YEARS (LAST BIRTHDAY))
89 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore County MD. | |
| 10. CITY OR TOWN OF DEATH
Catonsville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Summit Nursing Home | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Claims Supvr. | |
| 12b. KIND OF BUSINESS OR INDUSTRY
Insurance | | | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Catonsville | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13e. STREET ADDRESS / ZIP CODE
309 Hilton Avenue 21228 | | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Anton Wolfel | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Christina Dietrich | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE YEAR OR DATES)
N/A | | 17. INFORMANT
1411 Tieman Drive
Arthur M. Lapp Glen Burnie, MD 21061 | | | |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>acute Coronary Thrombosis</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>arterio sclerotic / heart disease</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Age</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>unknown</u> | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Depression</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>10/25</u> , 19 <u>68</u> , to <u>8/29</u> , 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>8/29</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>Cliff Ratliff</u> | | DEGREE
M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
8-31-85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
CLIFF RATLIFF, JR., M.D. P.A. | | 22e. ADDRESS
5772 WESTVIEW MALL 21228 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
9/3/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Baltimore National | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore City, Maryland | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
MacNabb Funeral Home Catonsville, MD | | | | 25a. DATE REC'D. BY REGISTRAR
SEP 4 1985 | | | |
| | | | | 25b. REGISTRAR'S SIGNATURE
<u>Julia Davidson-Randall</u> | | | |



RECEIVED

NOV 1964

NOV 1964

NOV 1964

[Faint, mostly illegible text and markings covering the page, possibly bleed-through from the reverse side.]

248107

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

21850

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | | | | | |
|---|--|---|--|---|--|--|---|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
AUDREY Louise VOLLERTHUM | | | 2a. DATE OF DEATH
MONTH DAY YEAR
08 28 '85 | | | 2b. HOUR
8:20A M | | | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Mar 30, 1929 | | 6. AGE (IN YEARS LAST BIRTHDAY)
56 YRS | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE COUNTY, MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
TOWSON | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
GREATER BALTIMORE MEDICAL CENTER | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Secretary | | 12b. KIND OF BUSINESS OR INDUSTRY
Steel (Beth.) | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | 13b. COUNTY
--- | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
5905 Plumer Avenue 20206 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Paul Oscar Mueller | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Anna Marie Mayr | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
----- | | 17. INFORMANT
ADDRESS
Henry Vollerthum 5905 Plumer Ave. 21206 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ADENO CA WITH MULT BONE METASTASIS
DUE TO, OR AS A CONSEQUENCE OF
(b) MULTIPLE ORGAN FAILURE
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:10 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/26, 1985, to 8/28, 1985, that (I) (we) lost
saw the deceased alive on 8/28, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
M. El Defrawi M.D. | | | | | DEGREE
M.D. | | 22c. DATE SIGNED
8/28/85 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MOSEN M. EL DEFRAWI, M.D. | | | | | 22e. ADDRESS
GBMC - 6701 N. CHARLES ST. 21204 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
Aug 31, 1985 | | 23c. NAME OF CEMETERY OR CREMATORY
Holy Redeemer Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Md | | | | |
| 24. FUNERAL DIRECTOR
NAME
Dippel Funeral Homes, Inc.
7110 Belair Rd. Baltimore, Maryland 21206 | | | | | 25a. DATE REC'D. BY REGISTRAR
AUG 30 1985 | | | | | 25b. REGISTRAR'S SIGNATURE
John Gordon-Rodell | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and certified killed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

PO. COLBY FIRST

CHIEF MAN

D. W. W.


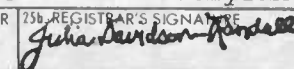


228149

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

21851

| | | | | | | | | | | | | | | | | | | | |
|--|--|------------------|----------------|---|--|--|--|---|----------------|--|--|---|--|---|------------------------------|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST
James | | | MIDDLE
E. | | | LAST
Waddey | | | 2a. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR
8/ 10/ 19 85 | | | 2b. HOUR
M
4:45
P M | | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
FEB. 16 1911 | | 6. AGE (IN YEARS)
LAST BIRTHDAY
74 YRS. | | 7. IF UNDER 1 YR.
MONTHS DAYS | | 8. IF UNDER 24 HRS.
HOURS MIN. | | 2c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
8/ 10/ 19 85 | | | 2d. HOUR
P M | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore County, MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Dundalk | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Liberty Pkwy & Dundalk Ave. | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Maintenance Man | | | | 12b. KIND OF BUSINESS OR INDUSTRY
Cemetery | | | | | |
| 13a. STATE
Maryland | | | | 13b. COUNTY
Baltimore | | | | 13c. CITY OR TOWN
Baltimore | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 13e. STREET ADDRESS
2126 Wilkens Avenue 21223 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Charles Waddey | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Emsworth Kent | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
NO | | | | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
216-10-7593 | | | | | | 17. INFORMANT
ADDRESS
Elizabeth White 2126 Wilkens Avenue 21223 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Arteriosclerotic Hypertensive Cardiovascular Disease</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above and <u>HEART & HEAD XX</u>
death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
 | | | | TITLE (SPECIFY)
M.D. Assistant | | | | MEDICAL EXAMINER | | | | DATE SIGNED
8/11/85 | | | | | | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Gregory R. Kauffman, M.D. | | | | ADDRESS
111 Penn St. | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | | 23b. DATE
Aug. 14, 1985 | | | | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park Cemetery | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Maryland | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Hubbard Funeral Home, Inc | | | | ADDRESS
4107 Wilkens Avenue 21229 | | | | 25a. DATE REC'D. BY REGISTRAR
AUG 14 1985 | | | | 25b. REGISTRAR'S SIGNATURE
 | | | | | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
25M

BP

DHMH - 17
(VR A15 ME (1))

352143



HEAD COLLOID

RECEIVED



CONFIDENTIAL 0001 1 000

249126

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

21852

REG. NO.

| | | | | | | | | | |
|--|--|---|---|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
ERNEST R. WAGNER | | | 2a. DATE OF DEATH
MONTH DAY YEAR
8 30 85 | | 2b. HOUR
6:30p M | | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
2 13 1922 | | 6. AGE (IN YEARS LAST BIRTHDAY)
63 YRS
IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
West Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE COUNTY MD. | | | |
| 10. CITY OR TOWN OF DEATH
DUNDALK | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
8214 Peach Orchard Road | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Self Employed Sales | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Dundalk | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
8214 Peach Orchard Road 21222 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Louis Wagner | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Julie Bernet | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WW II 233-28-0570 | | 17. INFORMANT
ADDRESS
Ada M. Wagner Same as 13e | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) Cardio Pulmonary Arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) Metastatic Adeno Carcinoma of Lung
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
x 10 min
x 6 months | | |
| MEDICAL CERTIFICATION | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)
BOLLINGER | | | | 22c. ADDRESS
VA-Hospital Loch Raven | | 22d. DATE SIGNED
8/30/85 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
9/3/1985 | | 23c. NAME OF CEMETERY OR CREMATORY
Gardens Of Faith | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Maryland | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Duda-Ruck, Inc. 7922 Wise Avenue Dundalk, Maryland 21222 | | | | 25a. DATE REC'D. BY REGISTRAR
SEP 4 1985 | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | |

BP

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

SWITZER



UNION PACIFIC

ALBERTA RAILROAD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/B4
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

21853

| | | | | | | | | | |
|--|--|--|---|--|--|--|--|---|--|
| 1 DECEASED NAME
(TYPE OR PRINT) EVELYN Estella WAGNER | | | 2a DATE OF DEATH MONTH DAY YEAR
August 29, 1985 | | | 2b HOUR
4:35P M | | | |
| 3 SEX
FEMALE | | 4 RACE
White | | 5 DATE OF BIRTH
MONTH DAY YEAR
1 21 1818 | | 6 AGE (IN YEARS LAST BIRTHDAY)
67 YRS | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b CITIZEN OF WHAT COUNTRY?
USA | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Baltimore Co., MD | | | |
| 10 CITY OR TOWN OF DEATH
Parkville | | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
8220 Bon Air Road 21234 | | | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Assembler | | 12b KIND OF BUSINESS OR INDUSTRY
Bendix Instru | |
| 13a STATE
Maryland | | 13b COUNTY
Baltimore | | 13c CITY OR TOWN
Parkville | | 13d INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e STREET ADDRESS / ZIP CODE
8220 Bon Air Road 21234 | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
Walter Collins | | | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Edna Johnson | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
216-12-6020 | | 17 INFORMANT ADDRESS
John J. Wagner 8220 Bon Air Rd. 21234 | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) LUNG CANCER
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b SIGNATURE
K R Faulkner MD | | | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c DATE SIGNED
08/30/85 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)
Kendall R. Faulkner, M.D. | | | | 22e ADDRESS
Stella Maris Hospice
2300 Dulaney Valley Rd.-Towson, MD 21204 | | | | | |
| 23a BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b DATE
9/3/85 | | 23c NAME OF CEMETERY OR CREMATORY
Parkwood Cemetery | | 23d LOCATION
CITY OR TOWN COUNTY STATE
Baltimore,, Md/ | | | |
| 24 FUNERAL DIRECTOR
NAME ADDRESS
Dippee Funeral Homes, Inc.
7110 Belair Road Baltimore, Md. 21206 | | | | 25a DATE REC'D. BY REGISTRAR
AUG 30 1985 | | 25b REGISTRAR'S SIGNATURE
John Davidson-Randall | | | |

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WAC-NEW

2018108

226039

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

21854

| | | | | | | | | | | |
|---|--|---|--|--|--|---|--|---|---|--|
| 1 DECEASED NAME
(TYPE OR PRINT)
Mrs. Mildred Wagner | | | 2a DATE OF DEATH
MONTH DAY YEAR
August 7 1985 | | | 2b HOUR
M | | | | |
| 3 SEX
Female | | 4 RACE
Caucasain | | 5 DATE OF BIRTH
MONTH DAY YEAR
September 12 1919 | | 6 AGE (IN YEARS LAST BIRTHDAY)
65 YRS | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b CITIZEN OF WHAT COUNTRY?
United States | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Baltimore County MD. | | | | |
| 10 CITY OR TOWN OF DEATH
Randallstown | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
3600 Ann Hathaway Drive Apt. 1B | | | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b KIND OF BUSINESS OR INDUSTRY | | |
| 13a STATE
Maryland | | | 13b COUNTY
Baltimore | | 13c CITY OR TOWN
Randallstown | | 13d INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e STREET ADDRESS / ZIP CODE
3600 Ann Hathaway Drive 21133 | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
Charles Edward Mitchell | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Lillian (Klien) | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | | 16b SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
212-12-4454 | | 17 INFORMANT
NAME ADDRESS
Mrs. Lisa Fielder 21229 Maryland
115 A. N. Rock Glen Road Baltimore | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral Lyr (Lyr)</u>
DUE TO, OR AS A CONSEQUENCE OF (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }
DUE TO, OR AS A CONSEQUENCE OF (c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>9 mos</u> | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | | |
| 19a DATE OF OPERATION | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2) | | | | | |
| 21d INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from <u>Dec 27</u> , 19 <u>84</u> , to <u>Aug 7</u> , 19 <u>85</u> , that (I) (we) lost
saw the deceased alive on <u>July 19</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b SIGNATURE
<u>S. WEINER</u>
DEGREE | | | | | | | | 22c DATE SIGNED
<u>8/9/85</u> | | |
| 22d PHYSICIAN'S NAME (PRINT)
<u>S. WEINER</u> | | | | | 22e ADDRESS
<u>1900 E. Northern Parkway</u> | | | | | |
| 23a BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b DATE
8-10-85 | | 23c NAME OF CEMETERY OR CREMATORY
Lake View Mem. Park | | 23d LOCATION
CITY OR TOWN COUNTY STATE
Sykesville Baltimore Maryland | | | |
| 24 FUNERAL DIRECTOR
NAME
Loring Byers Funeral Directors, Inc.
8728 Liberty Road Randallstown, Maryland 21133 | | | | | 25a DATE REC'D. BY REGISTRAR
AUG 12 1985
<i>Julia Davidson</i> | | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 is not any injury, or other traumatic event, the medical examiner must be notified at once.

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DOWN



Handwritten notes and stamps at the bottom of the page, including a date stamp "JAN 1963" and various illegible markings.

228015

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

21855

REG. NO.

| | | | | | | | | | | |
|--|--|---|--|---|--|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) <i>Jorothy C. Walker</i> | | | 2a. DATE OF DEATH
MONTH DAY YEAR <i>Aug 8 1985</i> | | | 2b. HOUR
MIN. <i>4:30 PM</i> | | | | |
| 3. SEX
<i>Female</i> | | 4. RACE
<i>White</i> | | 5. DATE OF BIRTH
MONTH DAY YEAR <i>5 22 1910</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>75</i> YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>MARYLAND</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>BALTIMORE COUNTY MD.</i> | | | | |
| 10. CITY OR TOWN OF DEATH
<i>Towson</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>ST. JOSEPH HOSPITAL</i> | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>BUDGET ANA.</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>DEPT. OF ARMY</i> | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE <i>MARYLAND</i> | | | 13b. COUNTY <i>BALTIMORE</i> | | | 13c. CITY OR TOWN <i>PARKVILLE</i> | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>JAMES R. FRENCH</i> | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>RAE C. HAUPT</i> | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>NO</i> | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
<i>217 057 009</i> | | 17. INFORMANT
ADDRESS
<i>FAMILY RECORDS</i> | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Ca of Lung</i> | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>NO</i> | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<i>P.M. 19</i> | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY OFFICE FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (this hospital) attended the deceased from <i>8/8</i> , 19 <i>85</i> , to <i>8/8</i> , 19 <i>85</i> , that (we) last saw the deceased alive on <i>8/8</i> , 19 <i>85</i> , and that in (our) opinion death occurred on the date and hour and from the causes stated above, # (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<i>Lester A. Wall Jr MD</i> | | | | | | DEGREE
<i>MD</i> | | 22c. DATE SIGNED
<i>8/8/85</i> | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>LESTER A. WALL JR MD</i> | | | | | | 22e. ADDRESS
<i>7620 York Rd Towson MD 21204</i> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<i>BURIAL</i> | | | 23b. DATE
<i>AUG 12 1985</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>MORELAND Msm. PK.</i> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>PARKVILLE BALTO. MARYLAND</i> | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
<i>EVANS CHAPL OF MEMORIAL HARBOR</i> | | | | | | 25a. DATE REC'D. BY REGISTRAR
<i>AUG 14 1985</i> | | 25b. REGISTRAR'S SIGNATURE
<i>James W. Randle</i> | | |

MEDICAL CERTIFICATION

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CHIEF VENDOR



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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

21850

REG. NO.

| | | | | | |
|---|---|---|--|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT) Mary E. Walker | | | 2a. DATE OF DEATH MONTH DAY YEAR
August 18, 1985 | | 2b. HOUR
4:45P M |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
April 9, 1894 | | 6. AGE (IN YEARS (LAST BIRTHDAY))
91 YRS. | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore County MD. | |
| 10. CITY OR TOWN OF DEATH
Cockeysville | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Broadmead | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
---- |
| 13a. STATE
Maryland | | | 13b. COUNTY
Baltimore | 13c. CITY OR TOWN
Monkton | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Robert Craig | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Alexander | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
--- | | 17. INFORMANT ADDRESS
Mr. Wm. F. Walker III 17116 Whitley Road 2111 | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.(b) **HYPERTENSION**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I

MULTIPLE TRANSIENT ISCHEMIC EVENTS, CONGESTIVE HEART FAILURE

| | | | | | |
|--|--|--|--|---|---|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last
saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Walter R. Hepner III | | DEGREE
MD | | 22c. DATE SIGNED
8/19/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Walter R. Hepner III | | 22e. ADDRESS
Paper Mill Road Phoenix, Maryland 21131 | | | |

| | | | |
|---|-----------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
8-21-85 | 23c. NAME OF CEMETERY OR CREMATORY
Baltimore | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore City Md. |
|---|-----------------------------|--|---|

| | | |
|---|---|--|
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Mitchell-Wiedefeld Home 6500 York Road 21212 | 25a. DATE REC'D. BY REGISTRAR
AUG 23 1985 | 25b. REGISTRAR'S SIGNATURE
[Signature] |
|---|---|--|

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP _____

226123

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1, 2, and 3 and file them within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified by page 5.

1- FOR-
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

21857

REG. NO.

| | | | | | |
|---|---|---|---|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
Mr. Charles Henry Ward | | | 2a. DATE OF DEATH
MONTH DAY YEAR
August 7 1985 | | 2b. HOUR
M
P |
| 3. SEX
Male | 4. RACE
Caucasian | 5. DATE OF BIRTH
MONTH DAY YEAR
August 16 1899 | 6. AGE
(IN YEARS LAST BIRTHDAY)
85 | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore County | | |
| 10. CITY OR TOWN OF DEATH
Essex | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOW IN SUCH INSTITUTION, GIVE STREET ADDRESS)
Franklin Square Hospital | | 12a. USUAL OCCUPATION
(TYPE OF BUSINESS OR INDUSTRY)
Supervisor-Md | 12b. KIND OF BUSINESS OR INDUSTRY
Training School | |
| 13a. STATE
Maryland | | | 13b. COUNTY
Baltimore | 13c. CITY OR TOWN
Essex | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John Bernard Ward | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Etta Elwood | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
215-10-2604 | 17. INFORMANT
NAME ADDRESS
Mrs. Helen Marie Aymes
6636 Whitmore Court Glen Burnie Maryland | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiopulmonary Failure
DUE TO, OR AS A CONSEQUENCE OF
(b) Carcinoma of the Pancreas with Metastasis to the Liver
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from July 21 , 19 85 , to August 7 , 19 85 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on August 7 , 19 85 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> (we) did not view the body after death. | | | | | |
| 22b. SIGNATURE
Gary Johnson | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
8/7/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Gary Johnson | | 22e. ADDRESS
9000 Franklin Square Dr., 21237 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
08-10-85 | 23c. NAME OF CEMETERY OR CREMATORY
Lake View Mem. Park | 23d. LOCATION
CITY COUNTY STATE
Sykesville Carroll Maryland | | |
| 24. FUNERAL DIRECTOR
Loring Byers Funeral Directors, Inc.
8728 Liberty Road Randallstown, Maryland 21133 | | 25a. DATE REC'D. BY REGISTRAR
AUG 12 1985 | 25b. REGISTRAR'S SIGNATURE
Jill Davidson-Randall | | |

BP

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241032

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|---|---|--|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
MILTON D. WARNER | | | 2a. DATE OF DEATH
MONTH DAY YEAR
August 22, 1985 | | 2b. HOUR
M |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
Mar. 12, 1916 | | 6. AGE (IN YEARS LAST BIRTHDAY)
69 YRS. | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
West Virginia | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore County MD. | |
| 10. CITY OR TOWN OF DEATH
Timonium | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
2305 Killoran Road | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired - Auto | | 12b. KIND OF BUSINESS OR INDUSTRY
Salesman |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | 13b. COUNTY
Baltimore | 13c. CITY OR TOWN
Timonium | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Benjamin Warner | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
L. Post | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | 16b. SOCIAL SECURITY NO.
235-01-5874 | | 17. INFORMANT
ADDRESS
M. Ruth Warner, Same As #13e 21093 | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) ASCVD

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause lost.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

± 5 yrs

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

Alcoholism

| | | | | | |
|--|--|--|--|--|---|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (1) (this hospital) attended the deceased from 19 82, to 8, 19 85, that (1) (we) lost
saw the deceased alive on 3, 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (1) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Edward P. Costlow | | DEGREE
MD | | 22c. DATE SIGNED
8 23 85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Edward P. Costlow M.D. | | 22e. ADDRESS
2303 1905 York Road, Timonium, Md. 21093 | | | |

| | | | |
|--|----------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
8-24-85 | 23c. NAME OF CEMETERY OR CREMATORY
Parkwood Cemetery | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Parkville, Balto. Maryland |
| 24. FUNERAL DIRECTOR
NAME
Ruck Towson Funeral Home, Inc. | | ADDRESS
1050 York Rd
Towson, Md. 21204 | 25a. DATE REC'D. BY REGISTRAR
AUG 27 1985 |
| 25b. REGISTRAR'S SIGNATURE
June Davidson-Randall | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

200110

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CHIEF OF BUREAU

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242096

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

21859

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|--|--|---|---|---|---|--|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | 2a. DATE OF DEATH | | | 2b. HOUR | | | |
| CHRISTINA WEBER | | | 8 23 '85 | | | 12:45A | | | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
7 15 03 | | 6. AGE (IN YEARS LAST BIRTHDAY)
82 | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE COUNTY MD. | | | |
| 10. CITY OR TOWN OF DEATH
TOWSON | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
GBMC-6701 N. CHARLES ST. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
Homemaker | |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Cockeysville | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
1517 Applecroft Lane 21030 | |
| 14. FATHER'S NAME
Albert - Stepanek | | | | | 15. MOTHER'S MAIDEN NAME
Anny - Moravec | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | 16b. SOCIAL SECURITY NO.
218-50-5557 | | 17. INFORMANT
Cockeysville, 21030
Mrs. Anna Weil 1517 Applecroft Lane | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST
DUE TO, OR AS A RESULT OF
ARRHYTHMIA
(b)
(c)
DUE TO, OR AS A RESULT OF
PROBABLE M.I.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a
CEREBRAL ANOXIA | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| MEDICAL CERTIFICATION | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/22 1985, to 8/23 1985, that (I) (we) lost
saw the deceased alive on 8/23 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Phillip N. Phillips, M.D. | | | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
8/23/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
PHILLIP N. PHILLIPS, M.D. | | | | | | 22e. ADDRESS
GBMC-6701 N. CHARLES ST. | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
8-24-85 | | 23c. NAME OF CEMETERY OR CREMATORY
Dulaney Valley Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Timonium Balto. Md. | | |
| 24. FUNERAL DIRECTOR
NAME
Bryan W. Clary 10 W. Padonia Road | | | | | | 25a. DATE REC'D. BY REGISTRAR
AUG 26 1985 | | 25b. REGISTRAR'S SIGNATURE
John Davidson-Randall | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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COLLIER & FISHER

BRAND

246019

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

21860

1 - FOR
STATE
REGISTRAR

JOSEPH

WEBER

REG. NO.

1. DECEASED NAME
(TYPE OR PRINT)

JOSEPH

GEORGE

WEBER

2a. DATE OF DEATH

MONTH

DAY

YEAR

2b. HOUR

8. 20. 85

11. 25A

3. SEX

MALE

4. RACE

CAUC.

5. DATE OF BIRTH

MONTH

DAY

YEAR

9

12

01

6. AGE (IN YEARS LAST BIRTHDAY)

83

YRS.

IF UNDER 1 YEAR

IF UNDER 24 HRS.

MONTHS

DAYS

HOURS

MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

ILLINOIS

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

BALTIMORE COUNTY

MD.

10. CITY OR TOWN OF DEATH

Randallstown

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

Baltimore County General

12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)

Eng.-Plumbing

12b. KIND OF BUSINESS OR INDUSTRY

Eng.-Plumbing

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

MD.

13b. COUNTY

CARROLL

13c. CITY OR TOWN

Westminster

13d. INSIDE CITY LIMITS?

YES ☐NO ☒

13e. STREET ADDRESS / ZIP CODE

235 Leppo Rd.

21157

14. FATHER'S NAME

Joseph

MIDDLE

B.

LAST

Weber

15. MOTHER'S MAIDEN NAME

Moffitt

MIDDLE

Biese

LAST

Biese

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)

no

16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)

na

160-441-0176

17. INFORMANT

Robert J. Weber

ADDRESS

13e

18. CAUSE OF DEATH (Enter only one cause per line, (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cardiac Arrest

DUE TO, OR AS A CONSEQUENCE OF

(b)

Intestinal obstruction

DUE TO, OR AS A CONSEQUENCE OF

(c)

+ Hypoglycaemia

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

COPD, AGE.

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐NO ☐20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?YES ☐NO ☐21a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED
WHILE ☐ AT WORK ☐ NOT WHILE ☐ AT WORK ☐21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)21f. LOCATION
STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from 8/11, 1985, to 8/20, 1985, that (I) (we) last saw the deceased alive on 8/20, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

ATTENDING
PHYSICIAN ☐MEDICAL
DIRECTOR ☐STAFF
PHYSICIAN ☐

22c. DATE SIGNED

8.20.85

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

PURUSHOTTAM MITRA

22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)

Burial

23b. DATE

8/24/85

23c. NAME OF CEMETERY OR CREMATORY

Westminster

23d. LOCATION
CITY OR TOWN

Westminster Carroll

COUNTY

STATE

MD

24. FUNERAL DIRECTOR

Robert K. Pritts, Sr., Westminster, Md.

25a. DATE REC'D. BY REGISTRAR

AUG 28 1985

25b. REGISTRAR'S SIGNATURE

J. C. K. K. K. K. K.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use on the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

12 of 12
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241091

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

2 1 3 6

| | | | | | |
|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Weeks David Lee Weeks | | 2a. DATE OF DEATH
MONTH DAY YEAR
8/19/85 | | 2b. HOUR
5:27p M | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
8 19 1985 | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
Towson | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 6. AGE (IN YEARS LAST BIRTHDAY)
MONTHS DAYS HOURS MIN.
YRS. 2 | |
| 10. CITY OR TOWN OF DEATH
Towson | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
6701 N Charles St GBMC | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore County MD. | |
| 13a. STATE
Maryland | | 13b. CITY OR TOWN
Baltimore | | 13c. STREET ADDRESS / ZIP CODE
6701 N Charles St. 21204 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Ronald Lee Weeks | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Darlene Elizabeth Heffner | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | |
| 16b. SOCIAL SECURITY NO.
--- | | 17. INFORMANT
ADDRESS
107 Courier Ct
Ronald L. Weeks Taneytown Md. 21287 | | 17b. KIND OF BUSINESS OR INDUSTRY | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory Failure
DUE TO, OR AS A CONSEQUENCE OF
(b) Extreme Prematurity (22 weeks)
DUE TO, OR AS A CONSEQUENCE OF
(c) ---
CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/19 , 19 85 , to 8/19 , 19 85 , that (I) (we) last saw the deceased alive on 8/19 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Dr. J. Torres | | DEGREE
MD | | 22c. DATE SIGNED
8/19/85 | |
| 22d. PHYSICIAN'S NAME | | 22e. ADDRESS
GBMC | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
8-30-85 | | 23c. NAME OF CEMETERY OR CREMATORY
Meadow Branch | |
| 23d. LOCATION
(CITY OR TOWN)
Westminster Carroll Md. | | 23e. DATE RECEIVED BY REGISTRAR
AUG 26 1985 | | 23f. REGISTRAR'S SIGNATURE
S. Davidson | |
| 24. FUNERAL DIRECTOR
NAME
Thomas D. Fletcher & Son | | 24b. ADDRESS
254 East Main Street Westminster, Md. 21157 | | 24c. DATE RECEIVED BY REGISTRAR
AUG 26 1985 | |

MEDICAL CERTIFICATION

BP

DHMH - 16 60M 7/B4
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR THE DIVISION OF VITAL RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH PAGES 3 AND 4 AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25MBP
DHMH - 17
(VR A15 ME (5))1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

21862

REG. NO.

| | | | | | | | | | | | |
|--|---------|--|-------------------|---|------|---|------|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | | 2a. DATE KNOWN OF DEATH | | | | 2b. HOUR | | | |
| SHERMAN WEINBERG | | | | 8 7 19 85 | | | | 11:18 | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS) | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD | | 2d. HOUR | |
| Male | White | Feb. 18, 1927 | 58 YRS. | MONTHS | DAYS | HOURS | MIN. | 8 7 19 85 | | 11:18 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| New York | | U.S.A. | | | | | | Baltimore County MD | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Randallstown | | Baltimore Co. General Hosp. | | | | Salesman-Home Improvement | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | |
| Maryland | | Baltimore | | Heberville | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 21207
7220 Oakhaven Circle Apt. 102 | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| Benjamin Weinberg | | | | Anna | | | | Unknown | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | | | | |
| Yes | | 132-16-2564 | | Mrs. Lillian Weinberg | | | | 21207
7220 Oakhaven Circle Apt. 102 Balto. MD. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Seizure disorder</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | | | |
| | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR
CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | TITLE (SPECIFY) | | | | DATE SIGNED | | | |
| | | | | M.D. Assistant | | | | 8-8-85 | | | |
| EXAMINER'S NAME
(TYPE OR PRINT) | | | | ADDRESS | | | | | | | |
| Ann M. Dixon, M.D. | | | | 111 Penn St., Balto., MD 21201 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | |
| Cremation | | 08-12-85 | | Westview Crematory | | | | Catonsville Baltimore MD | | | |
| 24. FUNERAL DIRECTOR
NAME | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | |
| Loring Byers Funeral Directors, Inc. | | | | AUG 12 1985 | | | | | | | |
| 8728 Liberty Road Randallstown, MD. 21133 | | | | | | | | | | | |

350010



241137

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

21863

| | | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Calvin Weitzel | | | 2a. DATE OF DEATH
MONTH DAY YEAR
August 24, 1985 | | 2b. HOUR
4:31P M | | | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
April 19, 1909 | | 6. AGE (IN YEARS LAST BIRTHDAY)
76 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore County MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Rossville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Franklin Square Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | | 12b. KIND OF BUSINESS OR INDUSTRY
Electrician | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Eastpoint | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Paul F. Weitzel | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Jeanette Watts | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
215038169 | | 17. INFORMANT
ADDRESS
Ethel P. Weitzel 7709 Balto. St. 21224 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiopulmonary arrest

DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) Myocardial Infarction (of inferior wall)
DUE TO, OR AS A CONSEQUENCE OF (c) Pneumonia | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: no | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from August 24, 1985 to August 24, 1985 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on August 24, 1985 , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (I) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Omar Kayaleh | | | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
8-24-85 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Omar Kayaleh, MD | | | | | | 22e. ADDRESS
9000 Franklin Square Drive 21237 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
8/27/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Oak Lawn Cemetery | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto. Md. | | |
| 24. FUNERAL DIRECTOR
NAME
Comelly Funeral Home | | | | | | 25a. DATE REC'D. BY REGISTRAR
AUG 27 1985 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 27 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 18, show any injury, or other traumatic event, the medical examiner must be notified and

BP

VC1115



218002

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

21864

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|-------------------------|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Gertrude A. Weller | | 2a. DATE OF DEATH
MONTH DAY YEAR
8-1-85 | | 2b. HOUR
5:30 AM | |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
June 28, 1903 | | 6. AGE (IN YEARS LAST BIRTHDAY)
82 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10. CITY OR TOWN OF DEATH
Towson, Balto. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
St Joseph Hospital | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Balto. Towson, MD | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Home maker | | 12b. KIND OF BUSINESS OR INDUSTRY
— | | 13a. STREET ADDRESS / ZIP CODE
206 Dunbeath Ct 21093 | |
| 13a. STATE
MD | | 13b. COUNTY
USA | | 13c. CITY OR TOWN
Lutherville | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
George Ostendorf | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Sara Johnson | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | |
| 16b. SOCIAL SECURITY NO.
212-05-1323 | | 17. INFORMANT
June Brooks | | ADDRESS
Balto, 629 Sussex Rd 21204 | |

| | | |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Septic shock prob 20 to E. coli UTI
DUE TO, OR AS A CONSEQUENCE OF
(b) Acute Congestive Heart Failure
DUE TO, OR AS A CONSEQUENCE OF
(c) — | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | |

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/1 , 19 85 , to 8/1 , 19 85 , that (I) (we) lost
saw the deceased alive on 7/31 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Morton C. Orman | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
8/1/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MORTON C. ORMAN | | | | 22e. ADDRESS
2936 E. BALTIMORE ST 21224 | | | |

| | | | | | | | |
|---|--|----------------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
Aug. 3, 1985 | | 23c. NAME OF CEMETERY OR CREMATORY
Gardens Of Faith Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Overlea Balto., Maryland | |
| 24. FUNERAL DIRECTOR
NAME
Ruck Towson Funeral Home, Inc. | | ADDRESS
1050 York Road | | 25a. DATE REC'D. BY REGISTRAR
AUG 2 1985 | | 25b. REGISTRAR'S SIGNATURE
John J. Jordan | |

MEDICAL CERTIFICATION

800818



220051

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

21865

| | | | | | | | | | | | |
|--|--|---|--|---|------------------------------|--|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
James G. WHEELER | | | 2a. DATE OF DEATH
MONTH DAY YEAR
August 3, 1985 | | 2b. HOUR
9:20 P.M. | | | | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
July 22, 1911 | | 6. AGE (IN YEARS LAST BIRTHDAY)
73 | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
YRS. | | IF UNDER 24 HRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore County MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Rossville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Franklin Sq. Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Buyer | | 12b. KIND OF BUSINESS OR INDUSTRY
Food Store | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE 13b. CITY OR TOWN 13c. CITY OR TOWN
Maryland Baltimore Essex 21221 | | | | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
1560 Alconbury Rd. 21221 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Harry B. Wheeler | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary T. Smith | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
212 01 1626 | | 17. INFORMANT
ADDRESS
Raymond A. Wheeler, Jr. Balto., Md. 21221 | | 17. INFORMANT
ADDRESS
135 Hampshire Rd. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Massive Gastrointestinal Hemorrhage
DUE TO, OR AS A CONSEQUENCE OF
(b) Esophageal Varices
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c) Micronodular Cirrhosis | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from July 23 , 19 85 , to August 3 , 19 85 , that (I) (we) lost saw the deceased alive on August 3 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Gregory R. Leib, M.D. | | | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
8/3/85 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Gregory Leib, MD | | | | | | 22e. ADDRESS
9000 Franklin Sq. Dr., 21237 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
Burial | | 23b. DATE
8/6/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Lorraine Pk. Cemetery | | 23d. LOCATION
Baltimore, Md. COUNTY STATE | | | | | |
| 24. FUNERAL HOME
Bruzdinski Funeral Home | | | | | | 25a. DATE REC'D. BY REGISTRAR
AUG 6 1985 | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained for 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers, page 1 and 2, would be filled within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

6935

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

234043

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will file a report.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

21866

| | | | | | |
|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 2a. DATE OF DEATH | | 2b. HOUR | |
| FIRST MIDDLE LAST
CHARLES B WHITE JR | | MONTH DAY YEAR
08 13 85 | | M | |
| 3. SEX | | 5. DATE OF BIRTH | | 6. AGE | |
| M ale | | MONTH DAY YEAR
12 27 19 | | YRS. MONTHS DAYS HOURS MIN.
65 | |
| 7a. BIRTHPLACE (COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| Texas | | U.S.A. | | Baltimore | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| TOWSON | | ST JOSEPH HOSPITAL | | Retired | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | |
| MD | | BALTO | | Parkville | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | |
| Charles B. White, Sr. | | Estelle Moore | | Yes | |
| 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| WW II | | Dorothy T. White - Same as #13e | | 454-09-4609 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| IMMEDIATE CAUSE (a) <u>Ventricular Tachycardia</u> | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Congestive Heart Failure</u> | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) <u>Coronary Artery Disease</u> | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Chronic Bronchitis</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (l) (this hospital) attended the deceased from 19 to 19, that (l) (we) lost saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (l) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE <u>Calvin Plitt</u> DEGREE <u>MD</u> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <u>8/13/85</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| Dr. Calvin Plitt | | Staff - St. Joseph's Hospital, Towson, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Burial | | 8-16-85 | | Parkwood | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE | | 23e. DATE REC'D. BY REGISTRAR | | REGISTRAR'S SIGNATURE | |
| Parkville, Balto. Md. | | AUG 19 1985 | | <u>John Davidson</u> | |
| 24. FUNERAL DIRECTOR NAME ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | REGISTRAR'S SIGNATURE | |
| Ruck Towson Funeral Home, Inc. Towson, Md. 21204 | | AUG 19 1985 | | <u>John Davidson</u> | |

2010-10

CHARLES
HENRY

WHITE

WHITE

COUNTY

TOWN OF ST. JOSEPH HOSPITAL

RD. BALTO



20 COTTON FIBER

RD. BALTO

240003

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

21361

FOR
1 - STATE
REGISTRAR

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Palestine | | FIRST MIDDLE LAST White | | 2a. DATE OF DEATH
MONTH DAY YEAR 8 22 85 | | 2b. HOUR 12 PM | |
| 3. SEX
FEMALE | | 4. RACE
BLACK | | 5. DATE OF BIRTH
MONTH DAY YEAR 10 24 34 | | 6. AGE (IN YEARS LAST BIRTHDAY)
50 YRS | |
| 7a. BIRTHPLACE
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
US | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore County MD. | |
| 10. CITY OR TOWN OF DEATH
Towson | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
Stella Maris Hospice | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
SECRETARY | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
MARYLAND | | | | 13b. COUNTY
BALTIMORE | | 13c. CITY OR TOWN
BALTIMORE | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
FRANCIS MUSE | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
RUTH BOWLER | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT
ADDRESS
WILLIAM WHITE 2819 EDGEcombe CIRCLE 21215 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Hemorrhage
DUE TO, OR AS A CONSEQUENCE OF:
(b) metastatic Disease
DUE TO, OR AS A CONSEQUENCE OF:
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: no | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8-6 , 19 85 , to 8-22 , 19 85 , that (I) (we) last saw the deceased alive on 8-22 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death. | | | | | | | |
| 22b. SIGNATURE
Dr Eddie Nakhuda | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
8-22-85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS
Stella Maris Hospice | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
8-26-85 | | 23c. NAME OF CEMETERY OR CREMATORY
GARRISON FOREST | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
GARRISON MARYLAND | |
| 24. FUNERAL DIRECTOR
NAME
E.L. PHILLIPS | | | | ADDRESS
1721 - 27 N. MONROE ST. | | 25. DATE REC'D. BY REGISTRAR
AUG 26 1985 | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, it should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

540003

2 2



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540003

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

248103

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | | | | | | | | |
|---|--|--|--|---|--|---|--|--|--|--|--|
| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 21868 | |
| 1. FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT)
JOHN D DOUGLAS WIGNER | | | | | 2a. DATE OF DEATH
AUG. 28, 1985 | | | 2b. HOUR
1258M | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
Sept. 1, 1918 | | 6. AGE (IN YEARS LAST BIRTHDAY)
66 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE COUNTY MD | | | | | |
| 10. CITY OR TOWN OF DEATH
TOWSON | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
ST. JOSEPH HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | | 12b. KIND OF BUSINESS OR INDUSTRY
Carpenter | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE Maryland 13b. COUNTY Baltimore 13c. CITY OR TOWN Towson | | | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
500 Bosley Ave. 21204 | | | | |
| 14. FATHER'S NAME
John D. Wigner, Sr. | | | | | 15. MOTHER'S MAIDEN NAME
Kathryn Sohn | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
213-05-8634 | | 17. INFORMANT ADDRESS
Nina A. Wigner - Same as #13e | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY INSUFFICIENCY</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>ADVANCED CHRONIC OBSTRUCTIVE PULMONARY DISEASE</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
<u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (this hospital) attended the deceased from <u>8-27</u> 19 <u>85</u> to <u>8-28</u> 19 <u>85</u> , that (we) last saw the deceased alive on <u>8/28</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (I) (did not) view the body after death. | | | | | | | | | | 22c. DATE SIGNED | |
| 22b. SIGNATURE
<u>Reynaldo Dr. Juela-Gomez</u> | | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
REYNALDO DR. JUELA-GOMEZ M.D. | | | | | 22e. ADDRESS
7620-YORK ROAD TOWSON MD 21204 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | 23b. DATE
8-29-85 | | 23c. NAME OF CEMETERY OR CREMATORY
Westview | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto. Md. | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Ruck Towson Funeral Home, Inc. Towson, Md. 21204 | | | | 1050 York Rd.
ADDRESS | | 25a. DATE REC'D. BY REGISTRAR
SEP 3 1985 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | | |

COLRPS

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MADE IN VIETNAM

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FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

21869

| | | | | | | | | | |
|--|--|--|--|---|--|--|--|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
Mamie Elizabeth Wilhide | | | 2a. DATE OF DEATH
MONTH DAY YEAR
Aug. 28 1985 | | | 2b. HOUR
5.09P M | | | |
| 3 SEX
Female | | 4 RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
01 05 1902 | | 6. AGE (IN YEARS LAST BIRTHDAY)
83 YRS | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore County MD. | | | |
| 10. CITY OR TOWN OF DEATH
Randallstown | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Baltimore Co. Gen. Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Washington | | 13c. CITY OR TOWN
Hagerstown | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
4 Spring Creek Rd. 21740 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Walter Wiles | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Clara Isnogle | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | | 16b. SOCIAL SECURITY NO.
212-09-4198D | | 17. INFORMANT
ADDRESS
Hospital Records | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pneumonia
DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Obstructive Pulmonary Disease
DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic cardiovascular disease | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
days |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Dec. 14, 1977, to August 28, 1985, that (I) (we) lost
saw the deceased alive on Aug. 28, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Suha Ozgun, M.D. | | | DEGREE | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
8-28-1985 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Suha Ozgun | | | | | 22e. ADDRESS
Springfield Hosp. Ctr. Sykesville, Md. 21784 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
8-31-85 | | 23c. NAME OF CEMETERY OR CREMATORY
Blue Ridge Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Thurmont Frederick Md. | | |
| 24. FUNERAL DIRECTOR
NAME G. Douglas Stauffer
ADDRESS 1621 Opossumtown Pike, Fred. Md. 21701 | | | | | 25a. DATE RECD. BY REGISTRAR
AUG 30 1985 | | 25b. REGISTRAR'S SIGNATURE
J. Davidson-Randall | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 to be kept within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or called.

BP

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2005-05-28

240018

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

21870

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | | |
|--|--|--|--|---|--|--|---|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Sophia Deaver Wilkens | | | 2a. DATE OF DEATH
MONTH DAY YEAR
Aug. 21 1985 | | 2b. HOUR
5:40 A.M. | | | | | | |
| 3. SEX
Female | | 4. RACE
Wht. | | 5. DATE OF BIRTH
MONTH DAY YEAR
10 - 19 - 1896 | | 6. AGE (IN YEARS LAST BIRTHDAY)
88 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Balto., Md. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Balto. Co. MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Cockeysville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Md. Masonic Home | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Nurse | | 12b. KIND OF BUSINESS OR INDUSTRY
Medical | | | |
| 13a. STATE
Md. | | | 13b. COUNTY
Anne Arundel | | 13c. CITY OR TOWN
Glen Burnie | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
6658 Shelley Rd. 21061 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Alfred Don Chesney | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Alice Deaver | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO.
213-22-0774 | | 17. INFORMANT
ADDRESS
George Deaver, Jr. 3408 Dayta Dr. Balto., Md. 21207 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary Arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a
Dementia | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (we) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Paul M. Rivas | | | DEGREE
M.D. | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
8-22-85 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Paul M. Rivas, M.D. | | | 22e. ADDRESS
Masonic Homes 21030 | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
Aug. 23, 1985 | | 23c. NAME OF CEMETERY OR CREMATORY
Woodlawn | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Woodlawn, Balto. Co., Md. | | | |
| 24. FUNERAL DIRECTOR
NAME
Mitchell-Wiedefeld Home, Inc. Balto., Md. 21212 | | | ADDRESS
6500 York Rd. | | | 25a. DATE REC'D. BY REGISTRAR
AUG 23 1985 | | | 25b. REGISTRAR'S SIGNATURE
Davidson-Randall | | |

MEDICAL CERTIFICATION

99

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certificate must be notified to the State Dept. of Health and Mental Hygiene.

BP



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246080

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified of such.

BP. _____

DHMH - 16 50M 1/BI
(VRA 15, 4)

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 21871 | |
|--|--|---|--|---|---|--|--|--|--|----------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) DANIEL J. WILLIAMS | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR 8 26 85 | | | 2b. HOUR
6:20 P.M. | | | |
| 3. SEX
MALE | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR 5 30 50 | | 6. AGE (IN YEARS LAST BIRTHDAY)
35 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
BALTO. Md. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE Co. MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Rosewood Centre | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
NONE | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
Md. | | 13b. COUNTY
BALTO. | | 13c. CITY OR TOWN
TOWSON | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
102 LINDEN TERRACE | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
CHARLES O. WILLIAMS | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MARY HOLMES | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) No | | | | | 16b. SOCIAL SECURITY NO.
214-76-3918 | | 17. INFORMANT
ADDRESS
ROSEWOOD RECORDS | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio respiratory arrest
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. Asphyxia
(b) Asphyxia
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Hydrocephalus, seizure disorder | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11-16 , 19 85 , to 8/26 , 19 85 , that (I) (we) lost
saw the deceased alive on 8/26/85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
R. GAUTHER MD | | | | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
8/26/85 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
R. GAUTHER | | | | | 22e. ADDRESS
Rosewood Centre Owings Mills | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
CREMATION | | | 23b. DATE
AUG. 28, 85 | | 23c. NAME OF CEMETERY OR CREMATORY
CARROLL CREMATION | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
HAMPSTEAD, MD. | | | | |
| 24. FUNERAL DIRECTOR
NAME
ELINE FUNERAL HOME | | | | | 25a. DATE REC'D. BY REGISTRAR
AUG 29 1985 | | 25b. REGISTRAR'S SIGNATURE
<i>William Harrison Handall</i> | | | | |

MEDICAL CERTIFICATION

244020

BALTO. 10.

U.S.A.

BALTIMORE CO.

NONE

102 LINDEN TERRACE

BALTO. 10.

MD.

HOLMES

MARY

WILLIAMS

O.

CHARLES

214-75-3915 ROSEWOOD RECORDS

NO

CREMATION AUG. 28, 1952 CARROLL CREMATION HAMPSTEAD, MD.

ELINE FUNERAL HOME WESTERSTOWN, MD.

21872

1 - FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | | | | | | | | |
|---|--|---|--|---|--|---|--|--|--|---|--|---|--|-------------------------------|--|----------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH | | MONTH | | DAY | | YEAR | | 2b. HOUR | |
| ALBERT | | | | WINER | | | | AUGUST 29, 1985 | | | | | | | | 8:32P.M. | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE | | (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | | | | |
| MALE | | CAUCASIAN | | SEPT. 4, 1921 | | 63 | | YRS. | | MONTHS | | DAYS | | HOURS | | MIN. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | |
| MARYLAND | | U.S.A. | | | | BALTIMORE COUNTY | | | | | | | | | | MD | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | |
| BALTIMORE | | 11 SLADE AVE., APT. 609 (21208) | | SELF-EMPLOYED | | REAL ESTATE | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS / ZIP CODE | | | | | | | | | |
| MARYLAND | | BALTIMORE | | BALTIMORE | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 3705 BRETON WAY 21208 | | | | | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | |
| FIRST | | MIDDLE | | LAST | | FIRST | | MIDDLE | | LAST | | | | | | | |
| JACOB | | | | WINER | | EVA | | | | | | | | | | KAGEN | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES) | | 17. INFORMANT | | ADDRESS | | | | | | | | | | | |
| NO | | 212-16-6319 | | MR. JAY WINER | | 3633 SUSSEX RD. 21207 | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | | | | |
| IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> | | | | | | | | | | | | 1 month | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Cardiac Failure</u> | | | | | | | | | | | | 2 months | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Mesothelioma</u> | | | | | | | | | | | | 1 year | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>0</u> | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH? | | | | | | | |
| | | | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED | | (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | | | | | | | |
| | | P.M. 19 | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY | | 21f. LOCATION | | CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | (AT HOME STREET FACTORY, OFFICE, FARM, ETC.) | | STREET | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>June 1, 1985</u> , to <u>Aug 29, 1985</u> , that (I) (we) lost
saw the deceased alive on <u>Aug 29, 1985</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | | | | DEGREE | | 22c. DATE SIGNED | | | |
| <u>Nathan Schnaper</u> | | | | | | | | | | | | MD | | 8/30/85 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | | | | | | | 22e. ADDRESS | | | | | |
| <u>Nathan Schnaper, MD</u> | | | | | | | | | | | | <u>Univ. of Md Cancer Center Univ. of Md</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | CITY OR TOWN | | COUNTY | | STATE | | | | | |
| BURIAL | | 8/30/85 | | OHEL YAKOV CEM | | BALTIMORE | | | | MARYLAND | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| NAME SOL LEVINSON & BROS., INC. | | | | | | | | | | | | SEP 5 1985 | | <u>Julia Davidson-Randall</u> | | | |
| ADDRESS | | | | | | | | | | | | 25c. REGISTRAR'S SIGNATURE | | | | | |
| 6010 REISTERSTOWN RD. BALTIMORE MD 21215 | | | | | | | | | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It must be returned by the hospital or attending physician.

58-3021



EXHIBIT FIBER

ALBUQUERQUE



225076

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

65 21873

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | |
|---|--|--|---|--|--------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
<i>Herman A Winter</i> | | | 2a. DATE OF DEATH MONTH DAY YEAR
<i>8 7 85</i> | | 2b. HOUR
<i>8:45A</i> | |
| 3. SEX
<i>Male</i> | | 4. RACE
<i>White</i> | | 5. DATE OF BIRTH MONTH DAY YEAR
<i>7 27 09</i> | | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
<i>76</i> YRS | | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>Balto., MD</i> | | 8. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Baltimore County, MD</i> | | 10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>St Joseph Hospital</i> | | |

| | | | | | |
|---|--|---|--|---|--|
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Produce</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>Winter Produce</i> | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
<i>MD</i> | | 13b. CITY OR TOWN
<i>Balto. City</i> | | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
<i>Bernard Winter</i> | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
<i>Wilhelmina Magledt</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>No</i> | | 16b. SOCIAL SECURITY NO.
<i>217-05-6229</i> | | 17. INFORMANT ADDRESS
<i>Eleanor M. Winter, 3123 Moravia Rd. Balto., MD 21214</i> | |

| | | | |
|---|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Cerebral Emboli</i>
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Chronic Atrial Fibrillation</i>
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Hypertensive + Atherosclerotic Heart Disease</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
|---|--|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
<i>P.M. 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE | | | |

| | | | | | | | |
|---|--|---|--|---|--|-----------------------------------|--|
| 22a. I certify that (I) (this hospital) attended the deceased from <i>8/7</i> 19 <i>85</i> to <i>8/7</i> 19 <i>85</i> , that (I) (we) last saw the deceased alive on <i>8/7</i> 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE
<i>Beatriz P. Dizon</i> | | 22c. DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22d. DATE SIGNED
<i>8/7/85</i> | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>BEATRIZ P. DIZON</i> | | 22f. ADDRESS
<i>7620 YORK RD. TOWSON, MD</i> | | | | | |

| | | | | | | | |
|--|--|-----------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
<i>Burial</i> | | 23b. DATE
<i>8-10-85</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Parkwood Cemetery</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE
<i>Balto. Balto, MD</i> | |
|--|--|-----------------------------|--|--|--|--|--|

| | | | | | |
|--|--|--|--|--|--|
| 24. GENERAL DIRECTOR'S NAME
<i>John C. Miller, Inc., 6415 Belair Rd. Balto., MD 21206</i> | | 25a. DATE REC'D. BY REGISTRAR
<i>AUG 9 1985</i> | | 25b. REGISTRAR'S SIGNATURE
<i>John Davidson-Randell</i> | |
|--|--|--|--|--|--|

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in the funeral director's office. Pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a report filed.



DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

248146

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 21874

| | | | | | |
|--|----------------------|--|--|--|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) IRENE G. WITTE | | MONTH DAY YEAR 08-31-85 | | 9:30 A.M. | |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR June 14, 1893 | | 6. AGE (IN YEARS LAST BIRTHDAY) 92 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore County General | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) sales | |
| 13a. STATE Maryland | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Arbutus | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Henry Weameart | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Worm | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE WAR OR DATES) n/a | | 16b. SOCIAL SECURITY NO 218-05-6502 | | 17. INFORMANT ADDRESS Mrs. Doris Lavender 5568 Oakland Rd. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEPTICEMIA | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DUE TO, OR AS A CONSEQUENCE OF (b) BILATERAL PNEUMONITIS | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) DEHYDRATION | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 8/28/85 P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/28/85 to 8/31/85 that (I) (we) last saw the deceased alive on 8/31/85 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Kaushalendra C. Singh, M.D. DEGREE MD | | | | 22c. DATE SIGNED 8/31/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) KAUSHALENDRAK SINGH | | | | 22e. ADDRESS BALTIMORE COUNTY GENERAL HOSPITAL | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9/4/85 | | 23c. NAME OF CEMETERY OR CREMATORY Baltimore National | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City Maryland | | 23e. DATE REC'D. BY REGISTRAR SEP 3 1985 | | | |
| 24. FUNERAL DIRECTOR NAME Ambrose Inc. ADDRESS 1328 Sulphur Spring 21227 | | 25a. DATE REC'D. BY REGISTRAR SEP 3 1985 | | | |
| 25b. REGISTRAR'S SIGNATURE Galia Davidson-Randall | | | | | |

SHIRTS

11



MADE IN U.S.A.

5% COTTON FIBER

219080

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, 3, 4 AND 5 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PH-1. RETAIN PAGES 1, 2, 3, 4 AND 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

21875

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | |
|--|---------------------|--|---|---|--|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) HELEN R WIXTED | | | 2a. DATE KNOWN OF DEATH
ESTIMATED 08 03 19 85 | | | 2b. HOUR
10 18 PM | | |
| 3. SEX
F | 4. RACE
W | 5. DATE OF BIRTH
MONTH 10 DAY 17 YEAR 21 63 YRS. | 6. AGE (IN YEARS)
LAST BIRTHDAY
63 YRS. | IF UNDER 1 YR.
MONTHS
0 DAYS
0 | IF UNDER 24 HRS.
HOURS
0 MIN.
0 | 2c. DATE PRONOUNCED DEAD
AUG 3 19 85 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Penna. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE COUNTY MD. | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN BUREAU FACILITY, GIVE STREET ADDRESS)
SAINT JOSEPH HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
MD | | 13b. COUNTY
BALTIMORE | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST Daniel MIDDLE Donne LAST Anderson | | 15. MOTHER'S MAIDEN NAME
FIRST Mae MIDDLE Anderson LAST Anderson | | 13e. STREET ADDRESS
8400 BERYL ROAD 21234 | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
218-46-5759
UNKNOWN | | 17. INFORMANT
Francis J Wixted | | ADDRESS
Same As 13e | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC CARDIO -
DUE TO, OR AS A CONSEQUENCE OF
VASCULAR DISEASE
(b) DIABETES MELLITUS
DUE TO, OR AS A CONSEQUENCE OF
(c) DIABETES MELLITUS | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR
CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that I am in charge of the report described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | |
| ACTUAL SIGNATURE
Paul F Guerin | | M.D. DEATH | | MEDICAL EXAMINER
1311 WESTERN BLVD
COCKEYSVILLE MD 21030 | | DATE SIGNED
8/4/85 | | |
| EXAMINER'S NAME
(TYPE OR PRINT) PAUL F GUERIN | | ADDRESS | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) Burial | | 23b. DATE
8/7/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Dulaney Valley | | 23d. LOCATION
CITY OR TOWN Baltimore COUNTY Maryland STATE | | |
| 24. FUNERAL DIRECTOR
NAME Leonard J Ruck Inc. ADDRESS Baltimore, Md | | | | 25a. DATE REC'D. BY REGISTRAR
AUG 5 1985 | | 25b. REGISTRAR'S SIGNATURE
John Davidson | | |

10

BALTIMORE COUNTY

BALTIMORE COUNTY

DEPT. OF PUBLIC WORKS

DEPT. OF PUBLIC WORKS



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242146

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

5

21876

1 - FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|---|--|--|---|--|---|---|---|---|--|
| 1 DECEASED NAME
(TYPE OR PRINT)
FIRST F MIDDLE WOLFF LAST HAROLD | | | 2a DATE OF DEATH
MONTH 08 DAY 18 YEAR 85 | | 2b TIME OF DEATH
5:43 PM | | | | |
| 3 SEX
MALE | | 4 RACE
WHITE | | 5 DATE OF BIRTH
MONTH 03 DAY 03 YEAR 24 | | 6 AGE (IN YEARS LAST BIRTHDAY)
61 YRS. | | 7 IF UNDER 1 YEAR
MONTHS 00 DAYS 00 HOURS 00 MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN)
NEW YORK | | 7b CITIZEN OF WHAT COUNTRY?
USA | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
COUNTY - BALTIMORE MD. | | | |
| 10 CITY OR TOWN OF DEATH
BALTO | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
ST JOSEPH HOSP | | | 12a OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
PRES. & OWNER | | 12b. KIND OF BUSINESS OR INDUSTRY
WOLFF ADV.AGENC | | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE MD 13b. CITY OR TOWN TOWSON 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13d. STREET ADDRESS / ZIP CODE
28 ALLEGHENY #2703 #21204 | | | | | | |
| 14 FATHER'S NAME
FIRST ISADORE MIDDLE WOLFF LAST WOLFF | | | 15 MOTHER'S MAIDEN NAME
FIRST LILLIAN MIDDLE KLEIN LAST KLEIN | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | 16b SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WWII-AF 060-18-9961 | | 17 INFORMANT MRS. ELLEN WOLFF APT. 2703 | | 18 ALLEGHENY AVE. TOWSON, MD 21204 | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Probable Anhythmia
DUE TO, OR AS A CONSEQUENCE OF (b) Hypertrophic Cardiomyopathy
DUE TO, OR AS A CONSEQUENCE OF (c) Aortic Insufficiency
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19a DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 85 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 8/18 , 19 85 , to 8/18 , 19 85 that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on 8/18 , 19 85 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b SIGNATURE
Samuel C.H. Lee, M.D. | | 22c. PHYSICIAN'S NAME (TYPE OR PRINT)
SAMUEL C.H. LEE, M.D. | | 22d. ADDRESS
St Joseph Hospital, Baltimore MD | | 22e. DATE SIGNED
8/19/85 | | | |
| 23a BURIAL, CREMATION, REMOVAL
(SPECIFY)
burial | | 23b. DATE
AUG. 20, 1985 | | 23c. NAME OF CEMETERY OR CREMATORY
BETH EL MEM. PARK | | 23d. LOCATION
RANDALLSTOWN BALTO. MD | | | |
| 24 FUNERAL DIRECTOR SOL LEVINSON & BROS., INC.
NAME 6010 REISTERSTOWN RD. BALTO., MD 21215 ADDRESS | | | | 25a DATE REC'D. BY REGISTRAR
AUG 27 1985 | | 25b REGISTRAR'S SIGNATURE
Wm Davidson-Randall | | | |

01010

WORLD B. OFF

01-01-01

COUWY

SELF-HELP

ALLEGEDLY

TOEY

WYON

01-01-01

10/10/10
10/10/10
10/10/10

234074

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH 17
(VR A15 ME (5))
15M 7/77

| FOR STATE REGISTRAR | | | | | | | | | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | 21877 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|----------------------|--|---|--|--|--|--|--|---|--|---|--|-------------------------|--|--|--|--|--|------------------------------|--|--|--|--|--|--|--|--|--|------------------------------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| 1- STATE REGISTRAR | | | | | | | | | | REG. NO. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) Florence Zebest | | | | | | | | | | 2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> MONTH DAY YEAR 8 17 1985 | | | | | | | | | | 2b. HOUR 12 P.M. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. SEX FEMALE | | 4. RACE WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR DEC. 21, 1915 | | 6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS. | | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS. HOURS MIN. | | 7c. DATE PRONOUNCED DEAD 8 17 1985 | | 7d. HOUR 12 P.M. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH RANDALLSTOWN | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BALTO. COUNTY GENERAL HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HAIRDRESSER | | | | 12b. KIND OF BUSINESS OR INDUSTRY COSMETOLOGY | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | 13a. STATE MARYLAND | | | | | | | | | | 13b. COUNTY BALTIMORE | | | | | | | | | | 13c. CITY OR TOWN BALTIMORE | | | | | | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | 13e. STREET ADDRESS 7205 BROOK CREST WAY, APT. A1 (21208) | | | | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST MAX ZEBEST | | | | | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST REBECCA UNKNOWN | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO. 579-14-5580 | | | | 17. INFORMANT ADDRESS POTOMAC, MD 20854
MRS. RUTH BLOOM 7816 MARY CASSATT DR. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac arrest
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural cause <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE Stanley Z. Feldenberg M.D. | | | | TITLE (SPECIFY) M.D. DPT | | | | MEDICAL EXAMINER | | | | DATE SIGNED 8/17/85 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Stanley Z. Feldenberg M.D. | | | | ADDRESS 11 E. Chase St. 2107 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | | 23b. DATE 8/18/85 | | | | 23c. NAME OF CEMETERY OR CREMATORY SHOREVIEW MISHMERES CEM | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE ROSEDALE BALTIMORE MARYLAND | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. | | | | 25a. DATE REC'D. BY REGISTRAR AUG 20 1985 | | | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 6010 REISTERSTOWN RD. BALTO., MD 21215 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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Film 6609 item 6

1- FOR 11/25/85 rja
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

5 2 1 8 7 8

| | | | | | | | | | |
|--|--|--|--|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
JUOZAS ZILEVICIUS | | | 2a. DATE OF DEATH
MONTH DAY YEAR
8 05 '85 | | | 2b. HOUR
11:55 PM | | | |
| 3. SEX
MALE | | 4. RACE
CAUC | | 5. DATE OF BIRTH
MONTH DAY YEAR
March 16, 1894 | | 6. AGE (IN YEARS LAST BIRTHDAY)
91 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Lithuania | | 7b. CITIZEN OF WHAT COUNTRY?
Lithuania | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE COUNTY MD. | | | |
| 10. CITY OR TOWN OF DEATH
TOWSON | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
GBMC-6701 N. CHARLES ST. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Musician | | 12b. KIND OF BUSINESS OR INDUSTRY
Music | |

| | | | |
|---|------------------------------|------------------------------------|---|
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | |
| 13a. STATE
Maryland | 13b. COUNTY
Balto. | 13c. CITY OR TOWN
Towson | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 13e. STREET ADDRESS / ZIP CODE
619 Stone Barn Road 21204 | | | |

| | | | |
|---|--|--|--|
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Albinas Zilevicius | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Amelia Zileviciute | |
|---|--|--|--|

| | | |
|---|---|--|
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
--- | 17. INFORMANT
ADDRESS
Mrs. Mary Z. Fulton 619 Stone Barn Road 21204 |
|---|---|--|

| | | |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIAC ARREST | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| DUE TO, OR AS A CONSEQUENCE OF
(b) THIRD DEGREE ATRIO-VENTRICULAR BLOCK | | 7/30-8/05/85 |
| DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

AORTIC STENOSIS

| | | | |
|------------------------|--|--|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
AORTIC STENOSIS | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
|------------------------|--|--|---|

| | | |
|--|---|---|
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |
|--|---|---|

| | | |
|---|--|---|
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE |
|---|--|---|

22a. I certify that (I) (this hospital) attended the deceased from **7/30**, 19 **85**, to **8/05**, 19 **85**, that (I) (we) lost
saw the deceased alive on **8/05**, 19 **85**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death.

| | | | |
|---|---------------------|--|-----------------------------------|
| 22b. SIGNATURE
<i>M. C. M. - Marques</i> | DEGREE
MD | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED
8/6/85 |
|---|---------------------|--|-----------------------------------|

| | |
|--|--|
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
maria c. miranda-marques, m.d. | 22e. ADDRESS
gbmc-6701 n.charles st. |
|--|--|

| | | | |
|---|----------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
8-8-85 | 23c. NAME OF CEMETERY OR CREMATORY
St. Gertrude | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Colonia New Jersey |
|---|----------------------------|---|---|

| | | | |
|--|--|--|--|
| 24. FUNERAL DIRECTOR
NAME
Mitchell Wiedefeld Home | ADDRESS
6500 York Road 21212 | 25a. DATE REC'D. BY REGISTRAR
AUG 7 1985 | 25b. REGISTRAR'S SIGNATURE
<i>Jana Davidson-Randall</i> |
|--|--|--|--|

A

COLLON 31623

ONE-THIRTY ST.

ARTIC STREETS

ARTIC STREETS

BALTIMORE COUNTY

WEDNESDAY

228052

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 100. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | 21879
REG. NO. | |
|--|--|--|--|--|--|--|--|--|--|--|--|
| 1- FOR STATE REGISTRAR | | | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) FLORENCE G. ZOLONAS | | | | | | | | | | 28. DATE KNOWN OF DEATH ESTI- MATED <input checked="" type="checkbox"/> AUG. 11, 85 | |
| 3 SEX FEMALE 4. RACE WHITE 5. DATE OF BIRTH DEC. 22, 1921 6. AGE (IN YEARS) 63 7. CITIZEN OF WHAT COUNTRY? USA 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CO. | | | | | | | | | | 29. DATE PRONOUNCED DEAD AUG. 11, 85 | |
| 10. CITY OR TOWN OF DEATH REISTERSTOWN 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 413 SACRED HEART LANE 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | |
| 13a. STATE MD. 13b. COUNTY BALTO. 13c. CITY OR TOWN REISTERSTOWN 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS 413 SACRED HEART LANE 2113 | | | | | | | | | | | |
| 14. FATHER'S NAME STANISLAUS GORSKI 15. MOTHER'S MAIDEN NAME WANDA RYDZEWSKI | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No 16b. SOCIAL SECURITY NO. 213-14-3209 17. INFORMANT MR. FRED C. ZOLONAS REISTERSTOWN MD | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ASCVD
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
16 days | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | |
| 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | | | | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | |
| 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE Stanley Z. Gelbenberg TITLE (SPECIFY) Deputy MEDICAL EXAMINER | | | | | | | | | | DATE SIGNED 8/12/85 | |
| EXAMINER'S NAME (TYPE OR PRINT) STANLEY Z. Gelbenberg MD. ADDRESS 11 E. Chase St 21202 | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL 23b. DATE AUG. 14, 85 23c. NAME OF CEMETERY OR CREMATORY GARDEN OF FAITH 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE, MD. | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME ELINE FUNERAL HOME REISTERSTOWN, MD. ADDRESS ADD865 | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR AUG 13 1985 25b. REGISTRAR'S SIGNATURE E. Davidson-Randall | |

BP

DHMH - 17
(VR A15 ME (5))
15M 7/76

ELINE FUNERAL HOME REISTERSTOWN, MD.

BURIAL

AUG. 14, 85 GARDEN OF FAITH

BALTIMORE, MD.

NO

STANISLAUS

GORSKI

HANDA

HOUSEWIFE

NO. BALTO. REISTERSTOWN

413 SACRED HEART LANE

REISTERSTOWN

413 SACRED HEART LANE

HOUSEWIFE

BALTO. MD. USA

BALTIMORE CO.

FEMALE WHITE DEC. 25, 1951 65

AUG. 11, 85

FLORENCE B. COLONAS

AUG. 11, 85 64